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Report of the International Atomic Energy Agency

Report of the International Atomic Energy Agency

Note by the Secretary-General**

1. The fifty-eighth report of the International Atomic Energy Agency, for the calendar year 2013 (GC(58)/3), is submitted herewith to the General Assembly. Major developments since the report was published will be covered by the annual statement of the Director General of the Agency to the General Assembly. The report has been transmitted in accordance with the provisions of article III, paragraph 1 (a), of the Agreement governing the relationship between the United Nations and the International Atomic Energy Agency (General Assembly resolution 1145 (XII), annex).

2. As only a limited number of copies of the report are available, it has not been possible to make a full distribution. Delegations are therefore requested to have the copies transmitted to them available during the discussion of this item.

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Sixty-ninth session
Item 27 of the provisional agenda*
Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

The present report has been prepared in response to General Assembly resolution 67/147. Obstetric fistula is a devastating childbirth injury that leaves women incontinent and often stigmatized and isolated from their families and communities. It is a stark outcome of gender inequalities, human rights denial and poor access to reproductive health services, including maternal and newborn care, and an indication of high levels of maternal death and disability. The report outlines efforts made by countries at the global, regional and national levels, and by the United Nations system, to end obstetric fistula. It offers recommendations to intensify these efforts, within a human rights-based approach, to end obstetric fistula in the days remaining for the achievement of Millennium Development Goal 5 and beyond, by improving maternal health, strengthening health systems, reducing health inequities and increasing the levels and predictability of funding.

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I. Introduction

1. The present report is submitted pursuant to General Assembly resolution 67/147, in which the Assembly requested the Secretary-General to submit to it at its sixty-ninth session a report on the implementation of the resolution under the item entitled "Advancement of women".

2. Sexual and reproductive health problems remain among the leading causes of ill health and death for women of childbearing age worldwide.[1] Far too many women suffer disproportionately from limitations on their right of access to health care, from unintended pregnancies, maternal death and disability, sexually transmitted infections, including HIV, cervical cancer, sexual and gender-based violence, and other problems related to their reproductive system. Educating and empowering women and girls are crucial for their well-being and fundamental to improving maternal health and preventing obstetric fistula. Additional steps must be taken to ensure all women worldwide have adequate access to health care, including sexual and reproductive health services, and to address the economic and sociocultural factors that negatively affect women.

II. Background

3. Ending obstetric fistula is a core component of all efforts to reduce maternal mortality and morbidity and improve maternal health. Any woman or girl suffering from prolonged or obstructed labour without timely access to an emergency caesarean section is at risk of developing obstetric fistula. Obstetric fistula is a severe maternal morbidity and a stark example of health inequity. Although fistula has been virtually eliminated in many countries, it continues to afflict many poor women and girls in the developing world who are without adequate access to health services. In order to eliminate obstetric fistula on a global scale, it is necessary to scale up country capacity to provide access to comprehensive emergency obstetric care, treat fistula cases, and address underlying medical, socioeconomic, cultural and human rights determinants. To end obstetric fistula, countries must ensure universal access to reproductive health services; eliminate gender-based social and economic inequities; prevent child marriage and early childbearing; promote education and broader human rights, especially for girls; and encourage community involvement.

4. Obstetric fistula has an immediate health impact for a woman and her child and, left untreated, can have devastating medical and social consequences. There is a strong association between fistula and stillbirth, with research indicating that the majority of women (from 78 per cent up to 95 per cent) who develop obstetric fistula also deliver a stillborn baby.[2] A woman with fistula is not only left incontinent but may also experience neurological disorders, orthopaedic injury, bladder infections, painful sores, kidney failure or infertility. The odour from

[1] World Health Organization (WHO), "Women's health", Fact Sheet No. 334 (updated September 2013). Available from www.who.int/mediacentre/factsheets/fs334/en/.

[2] Pierre Marie Tebeu and others, "Risk factors for obstetric fistula: a clinical review", *International Urogynecology Journal*, vol. 23, No. 4 (2012), pp. 387-394. See also Mulu Muleta, Svein Rasmussen and Torvid Kiserud, "Obstetric fistula in 14,928 Ethiopian women", *Acta Obstetricia et Gynecologica Scandinavica*, vol. 89, No. 7 (July 2010), pp. 945-951.

constant leakage, combined with misperceptions about its cause, often results in stigma and ostracism. Many women with fistula are abandoned by their husbands and families. They may find it difficult to secure income or support, thereby deepening their poverty. Their isolation may affect their mental health, resulting in depression, low self-esteem and even suicide.

5. While precise figures are not available, it is estimated that more than 2 million women and girls are living with obstetric fistula.[3] Obtaining exact data for prevalence and incidence is extremely difficult given that fistula usually afflicts the most marginalized — the poor, vulnerable, often illiterate women and girls living in rural areas — and usually requires clinical screening to diagnose.

6. In order to prevent obstetric fistula, it is necessary to address the root causes of maternal mortality and morbidity, including poverty, gender inequality, barriers to education — especially for girls — child marriage and adolescent pregnancy. Hence, economic and sociocultural changes are required. Health-care costs can be prohibitive for poor families, especially when complications occur. These factors contribute to the three kinds of delay that impede women's access to health care: (a) delay in seeking care; (b) delay in arriving at a health-care facility; and (c) delay in receiving adequate care once at the facility. Sustainable solutions for ending obstetric fistula therefore require accessible functioning health systems, adequately trained health professionals, reliable access to essential medicines and equipment and equitable access to high-quality reproductive health services.

7. Adolescent girls are particularly at risk of maternal deaths and morbidities, including fistula. If a girl's pelvis and birth canal are still developing, she is at a higher risk of health problems if she becomes pregnant. Each year, approximately 7.3 million births occur among girls under the age of 18 years in developing countries, with 2 million of these births occurring among girls younger than 15 years of age.[4] Complications from pregnancy and childbirth are a leading cause of death among girls aged 15 to 19 years in many low- and middle-income countries. Recent research, however, suggests that, besides adolescent girls, women aged 30 years and older are also at increased risk of developing complications and of dying during childbirth.[5]

8. During the period 2010-2020, an estimated 142 million girls will marry before 18 years of age.[6] Impoverished, marginalized girls are more likely to marry and give birth during adolescence than girls who have greater education and economic opportunities. Child marriage is a key driver of early pregnancy and of childbearing before adolescent girls are physically or emotionally ready, which heightens their risk of maternal death and morbidity, including obstetric fistula. Married adolescent girls often have difficulty accessing reproductive health services owing to factors such as social isolation and lack of awareness of their reproductive rights. All adolescent girls and boys, both in and out of school, married and unmarried, need

[3] www.who.int/features/factfiles/obstetric_fistula/en/.

[4] *State of World Population 2013: Motherhood in Childhood — Facing the Challenge of Adolescent Pregnancy* (United Nations publication, Sales No. E.13.III.H.1).

[5] Andrea Nove and others, "Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries", *The Lancet Global Health*, vol. 2, No. 32 (March 2014), pp. e155-e164.

[6] United Nations Population Fund (UNFPA), *Marrying Too Young: End Child Marriage* (New York, 2012).

access to comprehensive sexuality education and to health services, including those on sexual and reproductive health, to protect their well-being.

9. The three most cost-effective interventions to reduce maternal mortality and morbidity, including obstetric fistula, are: (a) universal access to family planning; (b) a trained health professional with midwifery skills at childbirth; and (c) timely access to high-quality emergency obstetric and neonatal care. Prevention is a core component of effective strategies to end obstetric fistula, including the eradication of poverty and inequalities.

10. Most cases of obstetric fistula can be treated through surgery, after which women can be reintegrated into their communities with appropriate psychosocial care. Research suggests, however, that there is a significant unmet need for fistula treatment. Currently, few health-care facilities are able to provide high-quality fistula surgery, owing to a lack of health-care professionals with the necessary skills, as well as essential equipment and life-saving medical supplies. When the services are available, many women are not aware of them or cannot afford or access them because of barriers, such as transportation costs. As shown on the Global Fistula Map,[7] a reported 13,858 fistula surgeries were performed in 2013. While not every identified fistula centre provided 2013 data, such numbers show that only a fraction of women with obstetric fistula receive treatment annually, particularly when compared to the estimated 50,000 to 100,000 new cases each year.[8] This highlights the need for intensifying resources to bridge this wide gap.

III. Initiatives at the international, regional and national levels

A. Major international initiatives

11. The Programme of Action of the International Conference on Population and Development, adopted in Cairo in 1994, recognized maternal health as a key component of sexual and reproductive health and reproductive rights. The Fourth World Conference on Women, held in Beijing in 1995, adopted the Platform for Action which recognized entrenched patterns of social and cultural discrimination as major contributors to sexual and reproductive ill health, including maternal death and disability. In 2013, at the request of the General Assembly, an operational review was undertaken by the United Nations of the implementation of the Programme of Action of the International Conference on Population and Development. The review recommended that States implement measures to eliminate preventable maternal mortality and morbidity, including obstetric fistula, through the provision of high quality maternal health care for all women (see E/CN.9/2014/4 and Corr.1).

12. In 2000, world leaders committed to Millennium Development Goal 5, a target of which was which to reduce the maternal mortality ratio by three quarters by 2015. In 2010, data showed that, for the first time, good progress had been made towards reaching Goal 5. The most recent United Nations estimates, however, show that only 11 countries with a baseline maternal mortality ratio of 100 or more in 1990 are on track to achieve the Goal by 2015. Some 63 countries are considered to

[7] http://globalfistulamap.org/.

[8] www.who.int/features/factfiles/obstetric_fistula/en/.

be making progress but the average annual decline of the maternal mortality ratio is insufficient to achieve it.[9]

13. In 2007, the General Assembly for the first time acknowledged obstetric fistula as a major women's health issue and adopted resolution 62/138, on supporting efforts to eliminate obstetric fistula, which was sponsored by a large number of States. Subsequently, in 2010 and 2012, the Assembly adopted resolutions 65/188 and 67/147, respectively, in which it called for a renewed focus on and intensified efforts for eliminating obstetric fistula. With each resolution, States reaffirmed their obligation to promote and protect the rights of all women and girls and to contribute to efforts to end fistula, including the global Campaign to End Fistula.

14. In October 2012, the Human Rights Council adopted resolution 21/6 on preventable maternal mortality and morbidity and human rights, in which it supported the application of a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity, including fistula. The resolution follows previous Human Rights Council resolutions related to the issue, including resolutions 11/8, 15/17 and 18/2.

15. In the agreed conclusions adopted at its fifty-eighth session in March 2014, the Commission on the Status of Women noted that progress towards reducing maternal mortality and morbidity had been slow and uneven. The Commission considered that levels of preventable maternal deaths and morbidity, including obstetric fistula, especially for adolescent girls, were still unacceptably high and highlighted significant gaps in funding for sexual and reproductive health.

16. At its forty-seventh session in April 2014, the Commission on Population and Development assessed the status of the implementation of the Programme of Action of the International Conference on Population and Development, 20 years after the Conference. The Commission adopted resolution 2014/1, in which it emphasized that particular attention should be given to the elimination of preventable maternal mortality and morbidity through, inter alia, strengthening of health systems, and ensuring equitable and universal access to quality, integrated and comprehensive sexual and reproductive health services.

B. Major regional initiatives

17. Road maps have been established to help Governments strengthen health systems and to plan and mobilize support for skilled attendance during pregnancy, childbirth and the postnatal period.[10] With support from the United Nations and other partner organizations, 43 African countries have developed road maps to accelerate the reduction of maternal mortality and have included maternal, newborn and child health issues in their poverty reduction strategies and health plans. Of these countries, 35 have developed operational plans for maternal and newborn

[9] WHO, *Trends in Maternal Mortality: 1990 to 2013 — Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division* (Geneva, 2014).

[10] See, for example, WHO Regional Committee for Africa resolution AFR/RC54/R9 of 3 September 2004.

health at the district level.[11] In July 2014, with a view to intensifying the efforts needed to achieve Millennium Development Goal 5, a coalition of United Nations organizations which support maternal and child health developed a new acceleration road map, aimed at enhancing support for countries and thereby saving the lives of an additional 140,000 women and 250,000 newborn children by the end of 2015.[12] The road map represents a vision of how well-planned financing, cooperation and coordination can ultimately lead to the elimination of all preventable maternal mortality and morbidity, including obstetric fistula, in high-burden countries.

18. In 2006, at its eighth ordinary session, the Executive Council of the African Union endorsed the Continental Policy Framework on Sexual and Reproductive Health and Rights. The framework, known as the Maputo Plan of Action for the Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights, addresses reproductive health challenges in Africa and contains a substantial component on obstetric fistula, which calls for strengthening of the health sector and increased resource allocations to health. While some progress has been made in implementing the Maputo Plan of Action, resources remain very limited, with few countries having a budget line for sexual and reproductive health. Not all countries have recommitted to the extension of the Maputo Plan until 2015 to coincide with the targets of the Millennium Development Goals, but a comprehensive five-year review of the status of the implementation is to be submitted to the African Union Commission in early 2015.[13]

19. The Campaign on Accelerated Reduction of Maternal Mortality in Africa promotes the intensified implementation of the Maputo Plan of Action. The United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), as well as donors and civil society organizations, provide support for the campaign at the national and regional levels. Numerous strategic policy dialogue and advocacy activities have been conducted since its launch. In 2013, the Campaign was launched in Comoros, Côte d'Ivoire, Guinea, Mali and Seychelles. In addition, significant support and advocacy efforts were undertaken at the regional level to ensure the inclusion of reproductive maternal, newborn and child health in the post-2015 development agenda. Djibouti, Madagascar, Somalia and South Sudan were among the countries that launched the Campaign in 2014.

20. A regional fistula meeting organized by UNFPA in Senegal in 2013 brought together representatives of nine ministries of health,[14] fistula treatment centres, civil society organizations and professional associations from West and Central Africa. The objective of the meeting was to promote a more conducive and enabling environment to end obstetric fistula. Consensus was reached on key actions, including: a shift from a campaign model towards a more sustainable approach of integrating obstetric fistula services into maternal health services; provision of support to national capacity-building for the prevention and management of

[11] Triphonie Nkurunziza and others, "Progress report on the road map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa", *African Health Monitor*, No. 18 (WHO Regional Office for Africa, November 2013).

[12] United Nations, "Road map to accelerate achievement of maternal and newborn survival and reach Millennium Development Goals 4 and 5 (targets A and B)" (June 2014). Available from www.mdghealthenvoy.org/news/documents/.

[13] http://pages.au.int/carmma/documents/maputo-plan-action-5-year-review.

[14] Benin, Burkina Faso, Cameroon, Chad, the Congo, Guinea, Mauritania, the Niger and Senegal.

obstetric fistula; and increased advocacy efforts for resource mobilization at the national and international levels.

21. In the Arab States, Djibouti, Somalia, the Sudan and Yemen are working towards the prevention, management, surgical treatment and rehabilitation of women with obstetric fistula. In Djibouti, United Nations organizations are supporting two maternal health service centres to provide emergency obstetric and newborn care, improve post-partum care and expand the midwifery workforce. The Government, with the support of United Nations organizations and other partners, is planning to gather concrete data on the prevalence of fistula in order to estimate the magnitude of the problem. Somalia has a high incidence of obstetric fistula, and its main focus is on increasing the number of births attended by skilled personnel and on strengthening the human resources for health, including capacity-building for surgeons to master the techniques of fistula repair. In Yemen, United Nations organizations and development partners have provided support for the establishment in public hospitals of two centres for the surgical treatment of fistula and for the training of service providers for the centres.

22. In Latin America and the Caribbean, the Regional Inter-Agency Task Force for the Reduction of Maternal Mortality is a key player in coordinating regional strategies for maternal and newborn health. Several countries, including Argentina, Brazil, Colombia and El Salvador, have begun to develop and implement maternal morbidity surveillance systems. Regional standards for intercultural maternal health care are under development, with the aim of establishing a set of standard care protocols that can inform national norm-setting processes. This strategy facilitates government ownership of the process, while offering opportunities for South-South collaboration. In addition, to strengthen midwifery professional organizations in the region, Argentina, Ecuador, Guyana, Haiti, Paraguay, Suriname, Trinidad and Tobago and Uruguay are using the Member Association Capacity Assessment Tool, which was developed by the International Confederation of Midwives and partners as part of their strategic planning process. In the Caribbean, an additional six countries have developed comprehensive national sexual and reproductive health policies. Regional studies on adolescent pregnancies and local legislation that hampers access to reproductive health services for adolescents are currently in the planning phase.

23. South-South collaboration is promoted as a key strategy to ending obstetric fistula. In 2013, a national strategy outline on obstetric fistula was shared by Rwanda with Zambia and Eritrea. The Midwives Association of Ethiopia and the Midwives Association of Ghana have launched a twinning relationship to promote mentorship and facilitate increased sharing of knowledge and best practice; midwifery students from South Sudan are being trained in Uganda; and Afghanistan has collaborated with the Islamic Republic of Iran on a review of the midwifery training programme and curricula. Examples of partnerships and collaborations also include the fourth International Roundtable on China-Africa Health Cooperation, held in Gaborone in May 2013, followed by the convening of the Ministerial Forum on China-Africa Health Development in Beijing in August 2013. These initiatives have contributed to the mobilization of political and financial support for sexual and reproductive health and reproductive rights in Africa, including fistula prevention, repair and reintegration.

C. Major national initiatives

24. Countries are making progress in reducing maternal mortality and morbidity. Some 19 countries, including Cambodia, Equatorial Guinea, Eritrea, Nepal, Rwanda and Timor-Leste, have already achieved a 75 per cent reduction in their respective maternal mortality ratios between 1990 and 2013, reaching the Millennium Development Goal 5 target before 2015. Among countries that had a maternal mortality ratio of less than 100 in 1990, progress has been made in Chile (60 per cent reduction), China (67 per cent), the Islamic Republic of Iran (72 per cent), Jordan (42 per cent), Libya (52 per cent), Mexico (45 per cent), Qatar (51 per cent), Saudi Arabia (61 per cent) and the United Arab Emirates (53 per cent).[9] Notwithstanding the remarkable gains made in reducing maternal morbidity and mortality and in improving reproductive health, there are continuing challenges that need to be addressed.

25. Improving sexual and reproductive health must be a country-owned and country-driven process. Countries need to allocate a greater proportion of their national budgets to health, with additional technical and financial support provided by the international community. Progress has been made in integrating obstetric fistula into the national health policies and plans of countries such as Bangladesh, Burkina Faso, Ghana, Guinea, Guinea-Bissau, Mali, Madagascar, Mozambique, Sierra Leone, the Sudan and Uganda. In Afghanistan, the revised reproductive health policy and strategy focuses on male involvement, emergency obstetric care, fistula and gender-based violence. In 35 fistula-affected countries, with Ghana recently joining the list, a national task force for fistula has been established to promote national leadership and ownership and serve as a coordinating mechanism for the activities of fistula partners nationwide. In addition, 33 countries have integrated prevention, management and treatment of fistula into their training curricula for health workers.[15]

26. Several countries are using innovative approaches that are generating positive results to raise awareness and increase access to treatment. Sierra Leone established a toll-free hotline to provide information about fistula and the availability of treatment. The initiative has contributed to a significant increase in the number of women referred to and treated at Aberdeen Women's Centre. Toll-free hotlines also exist in Burundi (in partnership with Médecins sans frontières, Belgium), Cambodia and Kenya. In the United Republic of Tanzania, the mobile phone-based money transfer microfinancing service known as M-PESA, established in 2009, covers the transportation costs of impoverished fistula patients, particularly those from the most remote and hardest-to-reach areas, so they can have access to fistula surgery. The system also provides free accommodation and meals before and after surgery, thereby addressing major barriers to accessing fistula treatment. In Kenya, the non-profit organization One by One is using digital pens to collect and store data about patients and their follow-up, thereby improving the quantity and quality of data captured for monitoring, evaluation and research purposes.

27. In Bangladesh, the Ministry of Health and Family Welfare endorsed the National Strategy on Obstetric Fistula in January 2014, with a costed action plan under development. The Government also announced the creation of 3,000 midwifery posts. About 70 per cent of births in Bangladesh take place at home, so

[15] www.endfistula.org/public/pid/7441?feedEntryId=26654.

the creation of the midwifery posts will result in increased skilled birth attendance, potentially contributing to the reduction of maternal mortality and morbidity, including obstetric fistula. In Nepal, to improve quality of care, the Ministry of Health and Population, with the support of United Nations organizations and partners, is developing a training site for obstetric fistula. In addition, with relatively little information available on reproductive health morbidities in Nepal, a study documenting the prevalence of selected morbidities, including obstetric fistula, was begun in early 2014. Findings from this study will form the basis for the development of national strategies to eradicate obstetric fistula and other morbidities.

IV. Actions taken by the International Community: remaining gaps and challenges

A. Prevention strategies and interventions to achieve maternal health goals and eliminate obstetric fistula

28. Three key evidence-based interventions are essential to prevent maternal deaths and disability, including fistula; namely: (a) family planning, (b) skilled birth attendance at every delivery and (c) access to emergency obstetric and newborn care, in the context of sexual and reproductive health services. In 2003, UNFPA and its partners launched the global Campaign to End Fistula, with the goal of making fistula as rare in developing countries as in the industrialized world. UNFPA serves as the secretariat of the International Obstetric Fistula Working Group, the main decision-making body of the Campaign to End Fistula. The Campaign focuses on three key strategies: prevention, treatment and social reintegration. It is active in over 50 countries in Africa, Asia, the Arab region and Latin America, and brings together more than 90 partner agencies at the global level and many others at the national and community levels. Since the launching of the Campaign, UNFPA has directly supported more than 47,000 fistula repairs, and non-governmental partners, such as EngenderHealth and Women and Health Alliance International, have supported thousands more.[16]

29. Midwives play a crucial role in preventing maternal and newborn mortality and morbidity, including obstetric fistula, by providing high-quality skilled delivery care, and identifying when a woman's labour is prolonged or obstructed and referring her to emergency obstetric care, as required. When properly trained and supported by a functional health system, midwives can provide 87 per cent of the essential care needed by women and their newborn children, which could potentially reduce maternal and newborn deaths by two thirds.[17] While in developing regions the proportion of births attended by skilled health professionals, including midwives, increased globally from 56 per cent in 1990 to 68 per cent in 2012, vast disparities across regions remain. The lowest levels (50 per cent or below) of skilled care are found in Africa and South Asia, although these regions have increased attendance by 10 percentage points or more since 2000. Low levels of coverage are compounded by significant inequities, with large urban-rural gaps: over 32 million

[16] http://www.endfistula.org/.

[17] UNFPA, International Confederation of Midwives and WHO, *The State of the World's Midwifery, 2014: A Universal Pathway. A Woman's Right to Health* (New York, UNFPA, 2014).

of the 40 million births that were not attended by skilled health personnel in 2012 occurred in rural areas.[18] Since 2008, UNFPA, the International Confederation of Midwives (ICM) and other partners, have provided support to more than 50 low-resource countries to build competent midwifery workforces and fill the human resource gap in maternal health and increase skilled attendance at all births. In 2012 and 2013, over 500 midwives were trained in fistula prevention and early management activities in countries such as Afghanistan, Ethiopia, Nepal, Uganda and Zambia. In 2013, Pakistan began a two-year degree programme in midwifery, with a curriculum based on ICM guidelines.

30. Midwives are the front-line workers in the fight to prevent obstetric fistula and maternal mortality and must therefore be well trained, supported and equitably deployed in areas in which their services are most needed. To help advocacy efforts with Governments to enhance and scale up investments in midwifery, UNFPA, ICM and WHO launched, the second State of the World's Midwifery report in June 2014.[17] The report contains the most recent midwifery data from 73 high maternal mortality countries which account for 96 per cent of all maternal deaths, 91 per cent of all stillbirths and 93 per cent of all newborn deaths but have only 42 per cent of the world's midwives, nurses and doctors. Using innovative multimedia e-learning, UNFPA, in collaboration with WHO, the Intel company and the health organization Jhpiego, is expanding outreach and improving the quality of midwifery training, particularly in lifesaving skills. Nine e-modules for front-line health workers have been developed, including a module for midwives on the management of prolonged obstructed labour, which is often the cause of fistula. Over 400 midwives were inducted in the use of these innovative training modules in 2013.

31. Several countries are implementing policies to reduce financial barriers to maternal health care. Examples include Sierra Leone and, more recently, Kenya, which have both officially abolished user fees. Universal and accessible quality reproductive health care has helped to eliminate obstetric fistula in developed countries, and the recently launched initiative, "Every Newborn: an action plan for ending preventable deaths",[19] led by WHO, UNICEF and partners, calls for universal coverage of high-quality care with innovation; accountability and data; leadership, governance, partnerships and financing; and review of global and national goals, targets and milestones (for the period 2014-2035). Such strategies not only address newborn health but also help to eliminate preventable maternal deaths and morbidities, including obstetric fistula.

32. The Health Four Plus initiative is a collaborative effort of six United Nations organizations (UNFPA, UNICEF, WHO, World Bank, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women)). With the support of Governments, Health Four Plus is working in countries with high numbers of maternal and newborn deaths to accelerate progress to achieve Millennium Development Goals 4 and 5 by harnessing the collective power of each partner's strengths and capacities. At the country level, this programme seeks to increase equitable access to services for sexual, reproductive, maternal, child and newborn health, as well as prevent mother-to-child transmission of HIV by strengthening the health system and active community engagement.

[18] United Nations, *The Millennium Development Goals Report 2014* (New York, 2014).

[19] http://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/.

33. Family planning is crucial for preserving the lives and health of women and newborn children. It is estimated that contraceptive use has reduced maternal mortality by over 40 per cent.[20] It may also contribute to reducing the risk of recurrence of fistula in future pregnancies of fistula survivors. The International Conference on Family Planning, organized around the theme "Full access, full choice" and held in Addis Ababa in November 2013, underscored the important role of family planning in addressing maternal mortality and morbidity.[21] A steady and reliable supply of maternal health medicines is essential to saving lives during pregnancy and childbirth. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security procures essential supplies that save lives before, during and after pregnancy in high-burden countries. Since 2012, significant progress has been made in enhancing the procurement of reproductive health supplies as well as the capacity of national health systems to manage these supplies and to provide related services for family planning and improving maternal health. In 2013, seven life-saving maternal health medicines were available at more than 70 per cent of service delivery points in nine countries with high maternal mortality and morbidity.[22]

34. Women living with or recovering from fistula are often neglected and stigmatized. Most women who develop fistula remain untreated for the remainder of their lives, and the condition can easily recur in women whose fistula has been surgically treated but who receive little or no medical follow-up and then become pregnant again. Governments need to develop and strengthen systematic registration and tracking mechanisms for each woman and girl who has or has had an obstetric fistula in order to help prevent recurrence and ensure the survival and well-being of both mother and baby in subsequent pregnancies.

35. Raising awareness, and sensitizing and mobilizing communities are essential strategies for preventing fistula and maternal and newborn death and disability. Fistula survivors are key advocates in this effort. For example, in Ethiopia, the organization Healing Hands of Joy trains former fistula patients as safe motherhood ambassadors who educate women about antenatal care and safe delivery, contributing to an increase in health facility deliveries. The organization also focuses on the reintegration of fistula survivors through activities such as microloan programmes which provide economic opportunities for women to pay off medical expenses and support themselves and their families. One programme in particular, a beekeeping and honey production project, allows women who continue to suffer from incontinence to receive an income and become self-sufficient.[23]

B. Treatment strategies and interventions

36. While global progress is being made to increase access to fistula treatment for those women and girls in need of it, it is vastly insufficient. In 2013, more than 10,000 fistula surgeries were directly supported by UNFPA, a significant increase

[20] Saifuddin Ahmed and others, "Maternal deaths averted by contraceptive use: results from a global analysis of 172 countries", *The Lancet*, vol. 380, No. 9837 (14 July 2012), pp. 111-125.

[21] www.fpconference2103.org.

[22] Guinea, Haiti, Honduras, Liberia, Mali, Mozambique, the Niger, Sierra Leone and Timor-Leste.

[23] Healing Hands of Joy, *2013 Annual Report*. Available from http://healinghandsofjoy.com/images/stories/2013_hhoj_report.pdf.

from 2012, especially in countries such as Uganda, where over 1,436 women were surgically treated during the year, and Nigeria, in which there were about 6,000 fistula repairs in 2013, compared with 2,000 in 2008. Yet, tragically, only a fraction of those in need of treatment actually receive it. The International Federation of Gynaecology and Obstetrics, the International Society of Obstetric Fistula Surgeons and the Fistula Foundation have implemented a competency-based fistula surgery training programme to expand global treatment capacity. A dramatic and sustainable scaling-up of quality treatment services and trained and competent fistula surgeons is needed. Closing this gap should be a high priority in the global post-2015 development agenda.

37. To promote increased access to quality fistula treatment and care, two innovative fistula repair kits were launched by UNFPA and the International Society of Obstetric Fistula Surgeons. These kits provide high-quality instruments and specialist materials for surgical fistula repairs, as well as a high-quality, specialized operating table. In 2013, the pharmaceutical company Johnson & Johnson announced a donation of sutures for the kits, which will facilitate the treatment of 15,000 women with obstetric fistula.

38. Lack of awareness that treatment for fistula is possible and available and the high cost of accessing that treatment constitute major barriers to caring for women and girls suffering from fistula. Countries should make every effort to make fistula services accessible to all who need them, including through the provision, in strategically selected hospitals, of integrated fistula services which are available continuously and provide the full continuum of holistic care and support for the treatment, rehabilitation and vital follow-up of fistula survivors.

C. Reintegration strategies and interventions

39. To fully recover and heal from obstetric fistula requires not only medical or surgical treatment but also a holistic approach that addresses the psychosocial and socioeconomic needs of the survivors. Follow-up of fistula patients is a major gap in the continuum of care. Tragically, only a fraction of fistula patients are offered reintegration services in most settings, despite significant needs. All fistula-affected countries should track this indicator to ensure access to reintegration services; some countries are already using it to track progress in this area. In 2013, all surgically treated women in Chad were offered reintegration services, as were most of the women who underwent surgery in Sierra Leone. Intensive social reintegration of women and girls deemed inoperable or incurable remains a major gap.

40. Reintegration services must be holistic, comprehensive, continual and available for as long as needed. They should include counselling and follow-up throughout all phases of treatment and recovery, from the first point of contact to post-discharge from hospital, health education, family planning and income-generating activities, combined with community sensitization to reduce stigma and discrimination. Connecting fistula patients to income-generating activities provides a much needed livelihood, renewed social connections and a sense of purpose. Fistula Foundation Nigeria offers a model programme whereby fistula survivors, including those deemed inoperable and incurable, are provided with ongoing counselling, support and livelihood training and opportunities, as well as long-term follow-up to ensure their survival and well-being. In the Congo, a special focus has

been placed on the crucial component of psychosocial rehabilitation and support of survivors, with activities that feature development of a support guide for social workers and establishment of a network of fistula survivors at the community level. All fistula survivors should universally be offered social reintegration services. Yet in reality, in several countries, many survivors are deprived of such services.

D. Research, data collection and analysis

41. Obtaining robust and comprehensive data on fistula remains a challenge, particularly given the invisibility of fistula survivors and the lack of priority and resources accorded the issue at the global and national levels. Progress has been made in improving the availability of data, including the development and application of a standardized fistula module for inclusion in demographic and health surveys in an increasing number of countries, such as Benin, Cameroon, Chad, Cote d'Ivoire, Guinea, Guinea-Bissau, Haiti, Kenya, Mali, the Niger, Sierra Leone, Togo, Yemen and Zambia. In addition, the Global Fistula Map, launched in 2012, has been updated, enhanced and expanded, and provides a snapshot of the landscape of fistula treatment capacity and gaps worldwide. The Map reveals a severe lack of fistula treatment centres in countries which have the highest levels of maternal mortality and morbidity. Data gathered show that, while the availability of surgical treatment for obstetric fistula is growing, only a fraction of fistula patients receive treatment annually.

42. Responding to the call for cost-effective methods for obtaining solid data on fistula, a new model to estimate the incidence and prevalence of obstetric fistula in countries has recently been developed by researchers at the Johns Hopkins Bloomberg School of Public Health. In addition, to assess the relationship between surgical and treatment outcome and long-term quality of life, health, psychosocial and reintegration outcomes following fistula surgery, Johns Hopkins University, together with UNFPA, WHO and the MacArthur Foundation, is conducting a multi-country study. This landmark study has been completed in Bangladesh and is ongoing in Ethiopia, the Niger and Nigeria. The results of the study will assist in the development of a prognostic-based classification system for obstetric fistula, guide advocacy and inform cost-effective programmes and national strategies. Nevertheless, more research is needed to address effectively the problem of obstetric fistula.

43. Maternal death surveillance and response, a framework directed at preventable maternal mortality and morbidity, is increasingly being promoted and institutionalized in several countries. Maternal death and severe morbidity near-miss case reviews[24] are of crucial importance in improving the quality of obstetric care, which, in turn, prevents the occurrence of obstetric fistula. Inter-agency consultations, as part of the WHO Commission on Information and Accountability, have been organized in all regions to address the need for widespread

[24] Near-miss reviews are performed after the occurrence of a life-threatening event in which a woman is deemed to have nearly died owing to a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy. See WHO, *Evaluating the Quality of Care for Severe Pregnancy Complications: The WHO Near-miss Approach for Maternal Health* (Geneva, 2011). Available from http://whqlibdoc.who.int/publications/2011/9789241502221_eng.pdf).

institutionalization of maternal mortality and morbidity surveillance and response systems, and a technical framework to support countries in the implementation of the maternal death surveillance and response was developed and published in 2013.[25] Some 14 African countries, including Benin, Burundi, Eritrea, Ethiopia, Guinea, Ghana, Madagascar, Malawi, Mozambique and Rwanda, are moving towards systematic maternal death and severe morbidity case reviews to improve quality of care. In Bangladesh and Nepal, a national surveillance system is being initiated with the support of UNFPA to identify and treat hidden fistula cases.

44. To prevent the occurrence of obstetric fistula, timely access to quality emergency obstetric services is of paramount importance. To this end, it is essential to assess the current level of care and provide the evidence needed for planning, advocacy and resource mobilization in order to scale up such emergency services in every district. UNFPA, UNICEF, WHO and the Averting Maternal Death and Disabilities Programme at Columbia University in New York support emergency obstetric and newborn care needs assessments in countries with high rates of maternal mortality and morbidity. By 2014, some 30 countries with high maternal mortality rates had completed or initiated such assessments. Almost all of them have translated their survey findings into action plans, and seven are monitoring the progress made in relation to emergency obstetric and newborn care signal functions and the availability of skilled staff.

45. The Fistula Care project, led by EngenderHealth, completed a number of research studies on fistula. These studies have contributed to important findings on a community screening model for fistula in Nigeria; the documenting of a successful midwifery training facility (Aberdeen Women's Centre) in Sierra Leone; and a systematic review of the literature on the factors that influencing urinary fistula repair outcomes in developing countries. Another important multi-country research study, conducted through the Fistula Care project in collaboration with the United Nations Development Programme, UNFPA, UNICEF, WHO, the World Bank and the joint Special Programme of Research, Development and Research Training in Human Reproduction, showed that short-term (7 days) draining of the bladder with a catheter is as effective as longer term (14 days) catheterization for fistula repairs. This finding has major implications for reducing the risk of hospital infections, reducing costs and increasing the turnover of patients awaiting surgery repair.

E. Advocacy and awareness-raising

46. Over the past two years, sustained presence in the media, increased collaboration at the country and regional levels and enhanced coordination with partners has helped to ensure strong messaging and significant communications activities related to obstetric fistula. Efforts were made to mobilize countries in heavily affected regions, especially in Africa, with tailored tools, such as public service announcements and animations, some of which were translated into several local languages. To facilitate media and donor outreach and provide resources for more cohesive messaging around fistula, factsheets on key issues were developed, technically revised, widely shared and added to online resource kits.

[25] WHO and others, *Maternal Death Surveillance and Response: Technical Guidance Information for Action to Prevent Maternal Death* (Geneva, WHO, 2013). Available from http://apps.who.int/iris/bitstream/10665/87340/1/9789241506083_eng.pdf.

47. In 2013, the United Nations marked the first International Day to End Obstetric Fistula (23 May) with a special event at United Nations Headquarters. The historic occasion was commemorated with parallel activities by national authorities and Campaign to End Fistula partners throughout the world. In many countries, political leaders, first ladies, celebrities, health professionals and civil society organizations took part in the related events which featured awareness-raising and media outreach, as well as testimonies from fistula survivors on radio and television. Key messages called for fistula prevention and access to treatment and intensified actions aimed at ending obstetric fistula.

48. In 2014, the international community again commemorated the International Day to End Obstetric Fistula under the theme "Tracking fistula — transforming lives", reflecting the priority of strengthening the partnership to ensure that every woman in need of fistula-related services and follow-up is reached. Worldwide activities included global calls for accelerated action to end obstetric fistula and the inclusion of elimination of fistula in the post-2015 development agenda. Campaign partners launched a special documentary film, *mFistula*, which highlighted the power of mobile technology to reach poor and remote fistula survivors to enable them to access treatment and care.

F. Global financial and intensified support

49. A major challenge facing countries is the insufficiency of national financial resources for maternal health and obstetric fistula. The problem is compounded further by the low levels of official development assistance directed towards Millennium Development Goal 5. Contributions to the Campaign to End Fistula are vastly insufficient to meet needs and have steadily declined in recent years, in part because of the global financial crisis. An urgent redoubling of efforts is required to intensify resource mobilization in order to ensure that fistula does not once again become a neglected issue.

50. Efforts to end obstetric fistula are integrated into and supported by initiatives with a broader maternal health focus. These include the Muskoka Initiative: Maternal, Newborn and Under-Five Child Health, the Partnership for Maternal, Newborn and Child Health, actions supported through Health Four Plus and the Maternal Health Thematic Fund of UNFPA. The initiatives of the Campaign on Accelerated Reduction of Maternal Mortality in Africa and "Every woman, every child" continue to represent a key platform for the operationalization of the Global Strategy for Women's and Children's Health, including action on obstetric fistula.

51. Member States, the private sector and the general public continue to contribute to efforts to end fistula. In 2013, the Campaign to End Fistula received funding from private citizens, philanthropic foundations, such as Zonta International, and private corporations, including Johnson & Johnson, Total, Noble Energy, Virgin Unite and the MTN Foundation. In addition, private sector partners mobilized their media and communication platforms and creative teams to support fistula advocacy and events, in particular the first International Day to End Obstetric Fistula.

52. Despite the expanding partnership and technological advances, vastly inadequate external and domestic resources continue to hamper significantly the effectiveness of the response to obstetric fistula. While prevention of obstetric fistula is increasingly integrated into maternal health interventions, the significant

backlog of women and girls awaiting treatment requires urgent prioritization of what is a neglected population. What remains now is to ensure adequate financing to meet the goal of ending obstetric fistula.

V. Conclusion and recommendations

53. Obstetric fistula is an outcome of socioeconomic and gender inequalities and the failure of health systems to provide accessible, equitable, high-quality maternal health care, including family planning, skilled attendance during childbirth, and emergency obstetric care in case of complications. Over the past two years, considerable progress has been made in focusing attention on maternal deaths and disabilities, including obstetric fistula. Despite these positive developments, many serious challenges remain. It is a human rights violation that, in the twenty-first century, the poorest, most vulnerable women and girls suffer needlessly from a devastating condition that has been virtually eliminated in other parts of the world. It is imperative that the international community act urgently to end preventable maternal and newborn mortality and morbidity, including obstetric fistula.

54. Significantly intensified political commitment and greater financial mobilization are urgently needed to accelerate progress towards eliminating this global scourge and closing the gap in the unmet need for fistula treatment. There is an urgent and ongoing need for committed, multi-year, national and international support to provide the resources necessary to reach all women and girls suffering from this condition and to ensure sufficient, sustainable and continued programming. Special attention should be paid to intensifying the provision of support to countries with the highest maternal mortality and morbidity levels. This will enable such countries to provide free access to fistula treatment services, given that most fistula survivors are poor and cannot afford the cost of treatment.

55. Better understanding of the social and economic burden resulting from poor reproductive health, including maternal and newborn health, has led to multisectoral approaches to address the linkages among poverty, inequity, gender disparity, discrimination, poor education and health. Efforts to improve women's health should systematically include education of women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives that would increase the age of marriage and delay early pregnancy. It is essential that these issues be emphasized in the post-2015 development framework.

56. There is a global consensus on the key interventions necessary to reduce maternal deaths and disabilities in the context of sexual and reproductive health services. There is an urgent need to scale up the three well-known, cost-effective interventions, emphasizing the crucial role of midwives to reduce the high number of preventable maternal deaths and disabilities.

57. The following specific, critical actions, within a human rights-based approach, must be taken urgently by Member States and the international community to end obstetric fistula:

Prevention and treatment strategies and interventions

(a) Greater investment in strengthening health systems, ensuring adequately trained and skilled human resources, especially midwives, obstetricians, gynaecologists and doctors, and provision of support for the development and maintenance of infrastructure. This includes investment in referral mechanisms, equipment and supply chains to improve maternal and newborn health services, with functional quality control and monitoring mechanisms in place for all areas of service delivery;

(b) Development or strengthening of comprehensive multidisciplinary national action plans, policies, strategies and budgets for eliminating obstetric fistula that incorporate prevention, treatment, socioeconomic reintegration and essential follow-up services;

(c) Establishment or strengthening of the national task force for obstetric fistula, led by ministries of health, to enhance national coordination and improve partner collaboration;

(d) Ensuring equitable access and coverage, by means of national plans, policies and programmes, to make maternal health services, particularly family planning, skilled birth attendance and emergency obstetric and newborn care and obstetric fistula treatment, geographically, financially and culturally accessible;

(e) Ensured and improved access to the full continuum of care, particularly in rural and remote areas, through the establishment and distribution of health-care facilities and trained medical personnel, collaboration with the transport sector to provide affordable transport options, and promotion and support of community-based solutions;

(f) Increased availability of trained, skilled fistula surgeons and permanent, holistic fistula services integrated into strategically selected hospitals, accompanied by quality control to ensure that only skilled fistula surgeons provide treatment to address the significant backlog of women awaiting care;

Financial support

(g) Increased national budgets for health, ensuring that adequate funds are allocated to sexual and reproductive health, including obstetric fistula;

(h) Incorporation into all sectors of national budgets of policy and programmatic approaches to redress inequities and reach poor, vulnerable women and girls, which should include the provision of free or adequately subsidized maternal and/or newborn health-care services and obstetric fistula treatment to all those in need;

(i) Enhanced international cooperation, including intensified technical and financial support, in particular to high-burden countries, to accelerate progress towards eliminating obstetric fistula and improving maternal health;

(j) Mobilization of public and private sectors to ensure that needed funding is increased, predictable and sustained;

Reintegration strategies and interventions

(k) Ensuring that all women who have undergone fistula treatment have access to social reintegration services, including counselling, education, skills development and income-generating activities;

(l) Ensuring that the special needs of women and girls deemed incurable or inoperable are met, in addition to providing other essential reintegration services;

(m) Development and strengthening of follow-up mechanisms, including indicators to track the fistula survivor's access to reintegration services;

Advocacy and awareness-raising

(n) Strengthening of awareness-raising and advocacy, including through the media, to effectively reach families and communities with key messages on fistula prevention, treatment and social reintegration;

(o) Mobilization of communities, including local religious and community leaders, women, men, girls and boys to advocate for and support universal access to sexual and reproductive health, ensuring reproductive rights, reducing stigma and discrimination, promoting gender equality and empowerment of women and girls, ending violence against women and girls and preventing child marriage, recognizing that the well-being of women and girls has a significant positive effect on the survival and health of children, families and societies;

(p) Empowerment of obstetric fistula survivors to contribute to community sensitization and mobilization as advocates for fistula elimination and safe motherhood;

(q) Strengthened and expanded interventions to keep girls in school, especially post-primary and beyond, ending child marriage and protecting and promoting gender equality and the empowerment of women and girls. Laws prohibiting child marriage must be adopted, enforced and followed by innovative incentives for families to avoid marrying off girls, including those in rural and remote communities, at early ages;

(r) Development of linkages and engagement with civil society organizations and women's empowerment groups to help eliminate obstetric fistula;

Research, data collection and analysis

(s) Strengthened research, data collection, monitoring and evaluation, including up-to-date needs assessments, on emergency obstetric and newborn care, to guide the planning and implementation of maternal health programmes, including those for obstetric fistula;

(t) Development, strengthening and integration within national health information systems of routine reviews of maternal deaths and near-miss cases, as part of a national maternal death surveillance and response system;

(u) Development of a community- and facility-based mechanism for the systematic notification of obstetric fistula cases to ministries of health and their recording in a national register, and acknowledgement of obstetric fistula as a nationally notifiable condition, triggering immediate reporting, tracking and follow-up.

58. The challenge of putting an end to obstetric fistula continues to require vastly intensified efforts at the national, regional and international levels. These efforts must include strengthening of health systems, gender and socioeconomic equality, empowerment of women and girls, and promotion and protection of their human rights. Substantial additional resources need to be forthcoming to accelerate progress, and funding must be increased. As the international community moves towards the post-2015 development framework, significantly enhanced support should be provided to countries, United Nations organizations, the Campaign to End Fistula and other global initiatives dedicated to improving maternal health and eliminating obstetric fistula.

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Sustainable development

International cooperation and coordination for the human and ecological rehabilitation and economic development of the Semipalatinsk region of Kazakhstan

Report of the Secretary-General

Summary

The present report is submitted in compliance with a request made by the General Assembly in resolution 66/193. It provides a status report on the human and ecological rehabilitation and economic development of the Semipalatinsk region of Kazakhstan.

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I. Introduction

1. The present report outlines the progress made in accelerating the development of the Semipalatinsk region[1] between 2011 and 2013, through programmes and actions organized by the Government of Kazakhstan and the international community, including United Nations agencies.

2. The Semipalatinsk test site, also known as "the Polygon", was the primary nuclear test site of the Soviet Union. In total, 456 nuclear tests were conducted between 1949 and 1989 at Semipalatinsk, including 340 underground and 116 atmospheric explosions. Altogether, nuclear explosions at Semipalatinsk were the equivalent of over 2,500 Hiroshima bombs. The Soviet Union had other nuclear test sites, but this was the only one close to major settlements. The resulting fallout from such tests severely affected the ecosystems of the region and the traditional way of life of its inhabitants.

3. The closure of the Semipalatinsk test site launched a new stage in the process of global nuclear non-proliferation and disarmament. President Nazarbayev and Kazakhstan are to be commended for their leadership in the global nuclear disarmament process, including the closure of the Semipalatinsk site on 29 August 1991, and the decision to renounce voluntarily the fourth largest nuclear arsenal in the world. The Government of Kazakhstan has achieved much since 2011 in the sphere of nuclear non-proliferation: in 2011, Kazakhstan hosted the International Forum for a Nuclear-Weapons-Free World and in 2012, it launched the international ATOM (Abolish Testing. Our Mission) project. As part of that project, anyone worldwide who stands against nuclear weapons can sign a petition online for presentation to Governments, calling for a complete ban on nuclear testing and helping to facilitate the early adoption of the Comprehensive Nuclear-Test-Ban Treaty. In addition, in 2012, the International Atomic Energy Agency (IAEA) agreed to deploy the first international nuclear fuel bank in Kazakhstan and the Presidents of Kazakhstan, the United States of America and the Russian Federation adopted a joint statement on trilateral cooperation at the former Semipalatinsk test site. In 2013, Kazakhstan hosted two rounds of talks between Iran and the P5+1 countries (China, France, Germany, the Russian Federation, the United Kingdom of Great Britain and Northern Ireland and the United States).

4. In 2009, the General Assembly unanimously adopted resolution 64/35 designating 29 August as the International Day against Nuclear Tests — a symbolic date, which was the first date of nuclear testing at the Semipalatinsk test site and the date on which the site finally closed.

5. Shortly after closing the site in 1991, Kazakhstan began helping the population of the affected territories in the East Kazakhstan region, aiding their recovery from the devastating consequences of nuclear explosions through social protection and health-care interventions. The General Assembly adopted seven resolutions between 1997 and 2011 (52/169, 53/1, 55/44, 57/101, 60/216, 63/279, and 66/193) calling on donor States and international development organizations to support the efforts of Kazakhstan to improve the social, economic and environmental situation in the Semipalatinsk region.

[1] The city of Semipalatinsk was renamed Semey in 2007.

6. Acknowledging the progress made in accelerating the development of the Semipalatinsk region between 2008 and 2011 through programmes and actions organized by the Government of Kazakhstan and the international community, including United Nations agencies, in 2011, the General Assembly adopted resolution 66/193. In that resolution, the Assembly urged the international community to assist Kazakhstan in formulating and implementing special programmes and projects for the treatment and care of the affected population and in its efforts to ensure economic growth and sustainable development in the Semipalatinsk region, including increasing the effectiveness of existing programmes. The Assembly also called upon the Secretary-General to continue his efforts to enhance world public awareness of the problems and needs of the Semipalatinsk region and report to the General Assembly at its sixty-ninth session on the progress made in implementing resolution 66/193.

7. The present report, accordingly, summarizes the actions taken since 2011 in the Semipalatinsk region by the Government of Kazakhstan, the United Nations and the international community.

II. Economic and social conditions

8. In its national vision and strategies, Kazakhstan has embraced the ambitious objective of becoming one of the 30 most developed countries. It is currently an upper-middle-income country, with steadily increasing gross domestic product per capita that has grown from $1,500 in 1998 to nearly $13,000 in 2013. Meanwhile, in recent years, the share of the population living in poverty, as measured by the national poverty line, has fallen from 5.5 per cent in 2011 to 3.8 per cent in 2012. That is a significant improvement over the 47 per cent of the population officially registered as living in poverty in 2001.

9. Although standards of living in Kazakhstan have risen significantly over the last decade, socioeconomic disparities remain significant between regions, rural and urban areas and women and men, in terms of access to services and opportunities. Living standards in rural areas remain much lower than those in urban areas and many social, regional and health disparities have yet to be erased. A number of social and health indicators do not yet correspond with the impressive level of economic development.

10. Kazakhstan has made good progress regarding the Millennium Development Goals. It has achieved Goals 1 to 3 ahead of time and has adopted a "Millennium Development Goals plus" agenda. It has made considerable strides in reducing child and maternal mortality, reducing the latter almost five-fold to 12.6 per 100,000 live births in 2013 (the target for 2015 had been 14), thus meeting Goal 5. Child mortality fell by 65 per cent between 1990 and 2012 from 54.1 per 1,000 live births to 18.7, indicating that Kazakhstan should achieve Goal 4 ahead of time. However, the country recognizes that particular targets have yet to be achieved, including some indicators for Goals 6 and 7, and that more efforts are needed to work on the unfinished Millennium Development Goals agenda.

11. As of 1 January 2014, over 962,000 people have been registered in East Kazakhstan as victims of nuclear testing at Semipalatinsk. The population today is economically vibrant, with great industrial potential and a strong agricultural sector. While notable progress has been made in respect of several economic and social

indicators, more remains to be done. In 2012, 3.4 per cent of the population in the region had an income below the subsistence minimum, compared to the national average of 3.8 per cent.

12. Between 2009 and 2012, the region saw child mortality among children under five fall from 23.4 per 1,000 live births to 18.2 (against the national average of 16.2). Between 2010 and 2013, infant mortality rates fell from 20.7 per 1,000 live births to 12.6. Meanwhile, the maternal mortality ratio fell by 60 per cent from 22.4 per 100,000 live births in 2011 to 13.1 in 2013.

13. Life expectancy at birth in the region stood at 68.6 years in 2012, just below the national average of 69.6, while women's life expectancy at 73.97 years significantly surpassed that of men at 63.31 years.

III. Institutional framework for assistance to the Semipalatinsk region

14. On 17 April 2014, the Government of Kazakhstan endorsed measures to improve social protection for victims of nuclear testing at the Semipalatinsk site. The plan comprises:

(a) A research programme entitled "Retrospective and prospective analysis of the medical and radio-ecological impact of the former Semipalatinsk nuclear test site on the population of surrounding area";

(b) Promotion of sanitary-epidemiological expertise through the above-mentioned analysis;

(c) Presentation of research on various aspects of environmental pollution (air, water and soil) across the former test site, including pollution levels in agricultural products;

(d) Promotion of ecological expertise regarding possible State reclassification of the former test site;

(e) Planned amendments and additions to the Law of the Republic of Kazakhstan, dated 18 December 1992 entitled "On the social protection of citizens affected by nuclear testing at the Semipalatinsk nuclear test site" if reclassification of the test site is granted;

(f) Provision of consultative and diagnostic services by health specialists from the Karaganda and Pavlodar regions and from regional consultative and diagnostic centres to residents of the Karkarala district in the Karaganda region and of the Bayanaul, Lebyazhye, and May districts of the Pavlodar region;

(g) Provision of 10 kinds of preventive medical examination for child and adult residents of the Karkarala district of the Karaganda region, who may have been affected by nuclear testing at the Semipalatinsk site;

(h) Establishment of the Republican Centre for Complex Dosimetry in the city of Kurchatov in the East Kazakhstan region;

(i) Establishment of a rehabilitation centre, offering 120 beds at the Institute of Radiation Medicine and Ecology in the city of Semey (formerly Semipalatinsk) in East Kazakhstan.

IV. Government programmes for the Semipalatinsk region

A. Health care

Retrospective and prospective analysis of the medical and radioecological impact of the former Semipalatinsk nuclear test site on the population of surrounding areas

15. The Ministry of Health has been allocated 83.8 million tenge to conduct a study on Law No. 148-V on the republican budget for 2014-2016, dated 3 December 2013. The results of the study will guide the adaptation of current legislation concerning social support for victims of nuclear testing. The Research Institute of Radiation Medicine and Ecology has already implemented or initiated the following scientific and technical projects:

(a) At the request of the Ministry of Health, a project entitled "Methods of integrated medical and genetic indication and prevention of radiation-induced effects among descendants of persons exposed to radiation" (2010-2012);

(b) At the request of the Ministry of Health, jointly with the State Medical University of the city of Semey, a project entitled "Development of science-based technologies for minimizing environmental risk, to prevent adverse effects on the health of the population" (2012-2014);

(c) A pilot feasibility project, entitled "Prospective cohort study of residents near the Semipalatinsk nuclear test site" (2013-2015), implemented jointly with the International Agency for Research on Cancer.

Creating the Republican Centre for Integrated Dosimetry in the city of Kurchatov

16. The Republican Centre for Integrated Dosimetry is being created as part of a State system to monitor and control the amount of radiation exposure experienced by personnel working with ionizing radiation sources and carrying out medical radiological procedures, as well as the amount of exposure suffered by the residents of the areas affected by nuclear testing. The centre will play a vital role in radiation safety for personnel and the wider public. It is being established as part of a programme to develop the atomic sector in Kazakhstan for the period from 2011 to 2014, with development prospects until 2020 (as approved by resolution No. 728 of the Government of Kazakhstan on 29 June 2011).

Creating a rehabilitation centre offering 120 beds, at the Research Institute of Radiation Medicine and Ecology, in the city of Semey

17. According to the Institute, about 360,000 people are at risk from radiation within the East Kazakhstan region. Their need for specialized medical care exceeds the medical capacity of the Institute several times.

B. Economic development

Transferring lands at the former Semipalatinsk test site for economic use

18. As part of the activities to secure the safety of the former Semipalatinsk test site within national budgetary programme No. 38 on "Securing radiation safety on the territory of the Republic of Kazakhstan", the National Nuclear Centre conducted an integrated ecological examination of the south-eastern part of the site between 2011 and 2013. The study covered an area of 2,500 km^2, including monitoring of the natural environment: soil and vegetable cover, water and air quality, fauna and agricultural products.

19. The exposure of the local population to radiation was assessed and 2,146.5 km^2 of land was recommended for full economic use, while 17.5 km^2 was not recommended for use (remaining part of the land reserves) and 336 km^2 being of limited use (for industry). Taking into account previous studies, over 30 per cent of the 6,060 km^2 that makes up the test site has now been examined. IAEA has approved the results as part of a joint technical cooperative study project entitled "Feasibility of economic use for the former Semipalatinsk test site".

C. Environment

Remediating polluted sites

20. To alleviate the effects of radiation at the test site, remediation (restoration) activities were carried out at sites polluted by radiation between 2011 and 2013. To restrict the distribution of radiation pollution from underground nuclear testing, reclamation works were conducted at six platform sites at Degelen, where maximum indicators of radioactive soil pollution were recorded. Clean soil was added over an area of 0.065 km^2 (6.5 ha) to a depth of 20 cm. That reduced surface radiation to 10 μSv/h, preventing the wind from spreading radioactive soil any further.

Creating the Republican Centre for processing and long-term storage of radioactive waste and ionizing radiation sources from atomic sector enterprises and other industries

21. The Republican Centre for processing and long-term storage of radioactive waste and ionizing radiation sources from atomic sector enterprises and other industries is being launched as part of the integrated development plan for Kurchatov Monocity in the East Kazakhstan region. It aims to make safe provision for the removal and recycling of highly radioactive liquid and solid waste, as well as promptly disassembling and recharging special-purpose installations and retired ampoule sources of ionizing radiation.

D. Education

22. To raise awareness and improve public knowledge regarding radioecology at the former test site, between 2011 and 2013 local residents (including schoolchildren and students) joined civil servants, tourists, foreign representatives, city visitors and media representatives on tours of the scientific and technical museum at the test site. In total, more than 3,000 people visited the museum over that period.

E. Joint programmes

23. In collaboration with the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund, the Government of Kazakhstan is implementing a joint programme in the East Kazakhstan region entitled "Raising the competitiveness of the region through innovative approaches to regional planning and social services". It addresses the particular needs of vulnerable people in the cities of Semey, Kurchatov and Oskemen and other affected areas in region. Suffering from economic stagnation, Semey is now plagued by an underdeveloped social infrastructure and a deteriorating quality of health and social services. The project aims to ensure the provision of adequate health services, while encouraging local economic development through capacity-building of entrepreneurship and business skills and improving community mobilization. It also aims to promote volunteerism and support non-governmental and community-based organizations in providing community services in their role as agents of change within society. The following results of the joint programme and related government initiatives have been achieved to date:

(a) The Akimat (Office of the Regional Governor) of East Kazakhstan came first out of 16 offices assessed for efficiency in 2013 whereas in 2012, it came last;

(b) Five districts of East Kazakhstan have successfully implemented self-government initiatives, applying energy efficient technologies and acting as a model for other districts and regions;

(c) Infant mortality rates fell from 20.7 per 1,000 live births in 2010 to 12.6 per 1,000 in 2013. The road map for improvement in mother and child health services in East Kazakhstan was developed after barriers to accessing quality services had been identified. Eventually, the road map was incorporated into the State plan to reduce maternal and infant mortality for the period 2014-2017, with an annual budget of $5 million;

(d) East Kazakhstan has become a pioneer in promoting the well-being of children as part of its efforts to strengthen information systems at the local level. It is the first region in the country to establish a family support mechanism, helping vulnerable families and children overcome social exclusion, keeping children with their families and addressing issues of violence against children;

(e) Maternal mortality fell by 60 per cent from 22.4 per 1,000 live births in 2011 to 13.1 in 2013. That is attributed to the overall improvement in health care for mothers and children both in hospital and in the primary health-care system.

V. Donor assistance to the Semipalatinsk region

International Atomic Energy Agency

24. Between 2011 and 2013, two IAEA technical cooperation projects were implemented in East Kazakhstan: KAZ/9/011, "Supporting radioecological monitoring" for the period 2009-2011, completed in 2012, and KAZ/9/012, "Supporting the transferral of former Semipalatinsk nuclear test site territories to economic use", which began in 2012 and will run for four years.

25. As part of project KAZ/9/011, IAEA provided support to Kazakhstan in upgrading knowledge for monitoring, including hands-on training for two experts in 2011 for implementing an indoor radon monitoring programme. In 2011 and 2012, expert missions assisted in setting up the calibration of radon measuring equipment and data interpretation for assessing risks relating to excessive radon levels (measured against applicable standards). In 2011, IAEA also provided radon monitoring equipment and equipment for calibrating radon detectors.

26. Project KAZ/9/012 is based on the 2010 KAZ/7/002 initiative, entitled "Supporting assessment of the Semipalatinsk nuclear test site territories for further economic use". The Agency is providing expert support for evaluating environmental studies of the former test site territory, training staff and providing equipment and materials for radiological measurement.

Government of Brazil

27. The Government of Brazil has financed a project, implemented by UNICEF, to promote a community-based approach to providing proper nutrition for children under the age of 5 ($93,460). That has raised the capacity of health-care providers in the field of infant and young child feeding (breastfeeding, and complementary/supplementary feeding), bringing improved counselling skills and practices, improved skills in the early identification of problems related to nutrition and more effective growth monitoring, focusing on the promotion of better nutritional practices for vulnerable infants and young children.

Government of Norway

28. The Government of Norway is supporting a UNICEF programme ($600,000) to develop a sustained and operational child protection mechanism to prevent and respond to child abuse, exploitation and family separation in line with international standards. It is contributing to the launch of an integrated approach to managing child protection issues in the Semipalatinsk region at the local level, including addressing violence against children, the independent monitoring of child rights and the prevention of child abandonment and institutionalization of those without parental care.

Humanitarian Aid and Civil Protection Department of the European Commission

29. The Humanitarian Aid and Civil Protection Department of the European Commission has worked jointly with UNICEF to implement a programme ($200,000) to strengthen the resilience of children living in areas exposed to disasters, improving school emergency preparedness and children's knowledge of disaster risk reduction measures, while enhancing appropriate skills. The programme also encourages children to bring their concerns to the authorities regarding urban development, natural disasters and the consequences of the former Semipalatinsk nuclear tests for public health.

United States Agency for International Development

30. In the Semipalatinsk region, the United States Agency for International Development (USAID) has funded its TB CARE I project, strengthening protocols for managing multi-drug-resistant tuberculosis and improving the coordination of general and prison tuberculosis services, while helping develop infection control

plans at tuberculosis facilities in the Semipalatinsk region and procuring the necessary equipment. Within TB CARE I, a number of national and regional training programmes have been undertaken, including for health officers from the city of Semey. The project is scheduled to end in December 2014.

31. Under a Development Credit Authority initiative, USAID supports a residential energy efficiency housing programme in cooperation with the Asian Credit Fund. The programme focuses on rural areas of the Semipalatinsk region and, by the end of 2013, had implemented 47 projects, including 28 for residential building insulation (worth 14.5 million tenge) and 19 for rehabilitation of residential heat supply systems (9.9 million tenge).

Turkish Cooperation and Coordination Agency

32. Between 2009 and 2012, UNDP implemented a project of its "Growing inclusive markets" initiative funded by the Turkish Cooperation and Coordination Agency. It was part of a regional initiative to encourage businesses to engage with the poorer end of society as clients and customers, as well as in their role of producers, employees and business owners. The aims of the project were to foster long-term sustainable development and raise awareness across the country of inclusive business models and market approaches. This was carried out by producing and disseminating a report featuring inclusive business model case studies from the region and by presenting the key barriers to achieving more inclusive markets alongside solutions for the problem. The country component was based in East Kazakhstan.

33. The primary target of achieving five successfully brokered inclusive investment projects was met; in fact, six projects were initiated a waste management project; a retail union; a syrmak (felt rug) making project; a project to assemble and service wheelchairs; a wool collection project; and a milk collection project (the latter as yet only in the monitoring stage, rather than implemented). They have created 20 jobs and will have additional indirect impacts (e.g. the milk collection feasibility study in the Zhitikara district estimated that 2,875 people would potentially benefit).

Government of Finland

34. Between 2009 and 2013, UNDP implemented a project entitled "Wider Europe: aid for trade in countries across Central Asia, South Caucasus and Western CIS", funded by the Government of Finland, which was a component of a larger initiative aimed at supporting inclusive growth in the region through the promotion of trade and the enhancement of the competitiveness of each country. It aimed to support the efforts of the countries concerned to reduce poverty and improve peoples' lives. Activities in the Semipalatinsk region focused on supporting the business initiatives of vulnerable groups and start-up businesses, in order to promote trade and employment. In addition, those activities were aligned with the current development strategy 2020 of the Government of Kazakhstan's, especially in the area of strengthening the capacity of small and medium enterprises, promoting the business environment and establishing an institutional setting to stimulate the private sector and export-related promotional measures.

35. As a result, 13 business consultancy providers and 32 online centres were established around the area; 9,052 owners of small businesses received training and

consultancy services; and grants were made to support 18 business plans via other funding sources, including the programmes of the Government of Kazakhstan entitled "Road map for business 2020" and "Employment 2020", with total funding amounting to 98.91 million tenge ($543,222). With financial support for inclusive and innovative business projects for micro and small businesses, the grant programme was worth $100,000. Under the "Road map for business 2020" programme, 16 business projects were approved and two business projects cofinanced; six projects were cofinanced under the "Employment 2020" programme and eight were fully financed by State programmes. As a result of the grant programme, 83.867 million tenge ($548,875) was attracted from State programmes.

VI. Priorities for future action

36. The Government of Kazakhstan, with the assistance of donors and the direct involvement of United Nations agencies, has carried out a considerable amount of work in the Semipalatinsk region over recent years. Numerous projects in the socioeconomic sphere and in the areas of environment, public health and education have been implemented. However, a lot remains to be done.

37. While significant efforts have been made within the framework of State, sectoral and regional programmes, as well as with international assistance, a more comprehensive and coherent approach is needed to alleviate the problems of the region.

38. The local development programme, run by United Nations agencies in the region, shows that harmonization of donor assistance to support current government priorities, coupled with active civil society support, is creating a good foundation for rehabilitation of the nuclear legacy and for general development. Nevertheless, more investment will be required in human development over the coming years, in order to ensure a stable pattern of development and growth for the region. To achieve this objective, governmental and international efforts will focus on the following priorities:

(a) Strengthening the health management system in the region to enable mother and child primary health-care services to identify and support vulnerable groups;

(b) Strengthening the capacity of local authorities, particularly in rural areas, in the use of evidence-based decision-making;

(c) Improving child and youth protection mechanisms by strengthening justice for children, preventing violence against children, promoting disaster risk preparedness, supporting vulnerable families with children and increasing the resilience of adolescents and young people in the face of associated risks;

(d) Promoting community awareness of the equal rights of vulnerable groups as an integral part of society;

(e) Increasing the efficiency of planning and the use of State resources in socioeconomic programmes at the local level, to ensure the protection of vulnerable groups;

(f) Capacity development to improve public well-being and further develop local self-governance;

(g) Enhancing access to quality social and economic services for vulnerable groups, including women and children;

(h) Providing the public with quality information on well-being and health.

VII. Conclusions and recommendations

39. The Semipalatinsk test site has become a symbol of nuclear disarmament and hope for a nuclear-free world. It hosted the signing of an agreement on the creation of a nuclear-weapon-free zone in Central Asia and there is every reason to believe that we may eliminate nuclear weapons, realizing the hope born in Semipalatinsk.

40. Work in the region has brought together various agencies with Member States and local communities, demonstrating that the task of regional rehabilitation is too huge to be conducted alone. Joint efforts from the international community are essential to the economic and social development of the Semipalatinsk region and are an excellent example of United Nations organizations and national partners joining forces to address complex regional issues. Streamlining the United Nations contribution through one joint programme has made it possible to address an array of issues, from maternity health to local development and citizen participation. The Secretary-General calls on the international community to support the joint work of the Government of Kazakhstan and the United Nations by:

(a) Enhancing the social inclusion of vulnerable groups in the region, especially in rural areas, with the aim of reducing their stigmatization and isolation and promoting their integration into the community;

(b) Strengthening coordination among various actors in the region to plan, implement and monitor inclusive regional social programmes and services, with special attention paid to vulnerable groups.

41. A nuclear-free world is a common goal to which humanity should aspire. The Secretary-General takes this opportunity to remind the world once again of the tragic consequences of nuclear testing and to encourage the global community to support the Government of Kazakhstan in accelerating the development of the Semipalatinsk region. Only by acting together, can the world be made a safer and better place.

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Promotion and protection of the rights of children: follow-up to the outcome of the special session on children

Follow-up to the special session of the General Assembly on children

Report of the Secretary-General

Summary

The present report assesses the steps taken in 2013 to achieve a world fit for children, highlighting the gaps in achievement as well as the strategic shifts necessary to meet the unmet goals.

The report has been prepared in response to General Assembly resolution S-27/2, adopted at the twenty-seventh special session in 2002, and resolutions 58/282 and 61/272, in which the General Assembly requested the Secretary-General to report regularly on progress made in implementing the Plan of Action included in the annex to the resolution, entitled "A world fit for children".

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I. Introduction

1. The present report provides the twelfth update on progress made in follow-up to the special session of the General Assembly on children, which took place in 2002. Delegations from 190 countries attended the session, adopting the Declaration and Plan of Action entitled "A world fit for children" (resolution S-27/2, annex). In doing so, Governments committed themselves to a time-bound set of goals for children and young people, with a particular focus on (a) promoting healthy lives; (b) providing quality education; (c) protecting children against abuse, exploitation and violence; and (d) combating HIV and AIDS.

2. In 2007, a commemorative plenary meeting on the commitments was held to review the progress made in implementing the Declaration and Plan of Action. In General Assembly resolution 65/1, entitled "Keeping the promise: united to achieve the Millennium Development Goals", Member States further committed to accelerating progress towards achieving the Goals.

3. There is much to celebrate as the twenty-fifth anniversary of the Convention of the Rights of the Child is celebrated, from declining infant mortality to rising school enrolment. The number of under-five deaths has fallen by nearly half, from 12.6 million in 1990 to 6.6 million in 2012, and the percentage of underweight children under 5 years old has declined from 28 per cent to 17 per cent. Maternal mortality has decreased dramatically, from 523,000 in 1990 to 289,000 in 2013.

4. Significant progress was achieved during 2013, but analysis shows that global averages often mask growing inequalities in key indicators, demanding immediate action. Despite significant progress in sanitation, 2.5 billion people do not have access to improved sanitation facilities, a decrease of only 7 per cent from the 2.7 billion in 1990. Globally, 34 million people were living with HIV at the end of 2011, approximately 3.3 million of whom were children younger than 15 years of age.

5. Throughout 2013, millions of children were affected by a range of sociopolitical crises, armed conflicts and natural disasters. They included the complex emergency in the Syrian Arab Republic, with its regional impacts; exacerbation of internal conflicts in the Central African Republic and South Sudan; the nutrition crisis throughout Africa; and the devastating typhoon in the Philippines. Armed conflict alone affected the lives of more than 250 million children under 5 years old.

6. Humanitarian situations undermine children's well-being, causing severe interruptions in their access to health, water and education services, and during conflict they expose children to grave violations of their rights. In the dozens of chronic humanitarian situations ongoing around the world, millions of children experience these conditions repeatedly, throughout their lives, severely limiting their ability to realize their potential.

II. Follow-up to the General Assembly special session on children

A. Planning for children

7. Estimates on global child poverty were produced for the first time in 2013, showing that 47 per cent of people living in extreme poverty were 18 years old or younger. The United Nations Children's Fund (UNICEF) is working in over 80 countries on child poverty analysis, including the development of the Multiple Overlapping Deprivation Analysis, a new tool to measure multidimensional poverty, which is initially being rolled out in 11 countries. In addition to its programmatic support in over 100 countries, UNICEF works with national partners in 31 countries to include social care and support services for children and families within social protection systems. The refocus on equity has translated into a leadership role for UNICEF, which is calling for inequalities to be specifically and boldly addressed throughout the post-2015 goals and framework.

B. Promoting implementation of the Convention on the Rights of the Child

8. As of mid-2014, the Convention on the Rights of the Child has been ratified or acceded to by 194 States, the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict has been ratified by 156 States and the Optional Protocol on the sale of children, child prostitution and child pornography has been ratified by 167 States. The third Optional Protocol to the Convention, on a communications procedure, entered into force in April 2014 and by 1 June had been ratified by 11 States. This new optional protocol provides a key procedural mechanism to the Committee on the Rights of the Child: it allows the Committee to receive and review communications on cases alleging violations of the rights of individual children or groups of children and to conduct country visits to investigate allegations of grave and systematic violations of children's rights.

9. Children with disabilities remain one of the most marginalized groups of children. The Convention on the Rights of Persons with Disabilities, which includes specific references to children, has been ratified by 147 countries as of mid-2014. In 2013 the General Assembly held a High-level Meeting on Disability and Development. It unanimously adopted a resolution on inclusion of persons with disabilities, with specific references to children.

C. Collaborating with partners and leveraging resources for children

10. In 2013, according to the latest statistics, members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development provided $134.8 billion in net official development assistance. This represented 0.3 per cent of these countries' combined gross national income. While this represents an all-time high, it falls far short of the United Nations target level of 0.7 per cent. After two consecutive years of diminishing budgets, the figure represents an increase of 6.1 per cent compared to 2012. The recent trend of a decrease in the share of aid allocated to the poorest counties in Africa has continued.

In addition, non-grant aid is increasing at a higher rate than grant aid. For bilateral assistance, non-grant disbursements (including equity acquisitions) rose by 33 per cent from 2012, while grants (including loan forgiveness) rose by 7.7 per cent.

11. The number of Global Programme Partnerships has continued to grow, and their potential for maximizing reach and impact on children's rights is clear. These partnerships play a convening role in global arenas, leverage additional resources for children, provide better advocacy outreach and mobilize new players at the global, regional and country levels. They also provide new platforms from which to raise attention on critical issues for children who do not benefit from international attention.

D. Monitoring progress

12. Monitoring of child outcomes has been continuously strengthened by the UNICEF-supported multiple indicator cluster surveys. Over 240 surveys have been undertaken in 100 countries, and 59 surveys were completed during the fourth round in 2012. Preparations for the fifth round of surveys was completed in 2013, with the participation of 45 countries. The data from most of the surveys will be used for the final assessment of the Millennium Development Goals and as the baseline for the post-2015 goals and targets. The Multiple Overlapping Deprivation Analysis has analysed child poverty and disparities in more than 50 countries, leading to more child-focused policies and processes.

13. A new statistical website — http://data.unicef.org — was launched and will replace the childinfo.org website. It represents the most comprehensive resource available for data on the situation of children and women.

14. Great advances have been made in the ability to gather information on real-time delivery of services to those who need them most. Systems like uReport, a free SMS-based messaging system for young people, is now on a national scale in Uganda and is going to scale in Nigeria and Zambia. It allows young people to send in an SMS notification of need, such as about gaps in programme delivery or to help advocate for specific policy changes. EduTrack and similar systems allow for real-time collection of information from teachers and monitors using simple mobile phones. In Zambia, Project Mwanza has shortened the return time for infant diagnostic tests for HIV from 30 days (on paper, by road) to a few seconds (through a text message). It delivers thousands of these notifications to health clinics every month.

15. The Monitoring Results for Equity Systems was applied to systematically identify, track and address bottlenecks impeding results for the most disadvantaged children, in more than 80 countries in 2013, a marked increase from 30 countries in 2012. While the application of the monitoring system varies by country, its determinants framework is resulting in more strategic programmes and improved monitoring of results for children. Key to the successful use of the approach is linking it to countries' national and subnational planning and monitoring systems, engagement of partners and communities, and use of monitoring data to inform action for a greater focus on equity in results.

16. In 2013, the governance indicator framework for child protection systems was aligned with the Monitoring Results for Equity Systems and piloted in Indonesia,

the Philippines and a number of Pacific Island States, indicating that findings from robust evidence inform programming and policymaking.

E. Supporting participation and self-expression by children

17. Significant progress has been made in promoting child participation. The right of children to be heard in decisions that affect them has been realized in many contexts through diverse initiatives and social accountability mechanisms at the national and subnational levels, as well as through consultative policy, budgeting and legislative development processes. In addition, a growing number of countries legally recognize the principle of respect for the views of the child and have made efforts to incorporate the right to be heard in administrative and legal proceedings. However, the Committee on the Rights of the Child has expressed concern that implementation is inadequate and of low quality.

18. The full realization of children's participation rights continues to be hampered by cultural and discriminatory attitudes and practices and by political, legislative and economic barriers. In 2013, the Secretariat of the United Nations Permanent Forum on Indigenous Issues, UNICEF and the Global Indigenous Youth Caucus launched an adolescent-friendly version of the United Nations Declaration on the Rights of Indigenous Peoples, seeking to equip these marginalized adolescents to advocate for realization of their rights.

19. A number of efforts have been made to include the voices and recommendations of children in the post-2015 agenda. Globally, thousands of children and young people participated in online and face-to-face consultations between 2012 and 2013. Efforts by States parties to establish national or subnational child and youth councils or parliaments reflect their intention to strengthen children's participation in matters that affect them. There is also evidence of engagement by children and adolescents in programme development and policymaking processes.

20. Evidence suggests that children are increasingly contributing to the Convention reporting process. Debates on the post-2015 development agenda have contributed to further evolvement of the concept, expanding the discourse from "participation" to "accountability". This implies a shift in power in which citizens hold Governments responsible for their actions as duty-bearers. There are indications that social accountability initiatives contribute to an enabling environment for realization of children's rights, by influencing the quality of governance, improving transparency in delivery of public services or empowering communities with information on their rights.

III. Progress in the four major goal areas

A. Promoting healthy lives

21. The number of child deaths fell to an all-time low in 2012: an estimated 6.6 million deaths. About 40 per cent of these deaths occurred during the first month of life. The global under-five mortality rate has fallen by almost 50 per cent, from 90 deaths per 1,000 live births in 1990 to 48 per 1,000 in 2012. However, the

reduction in neonatal deaths still continues to lag the survival gains in older children, underscoring where further efforts need to be concentrated. That is why a road map and joint action platform for the reduction of preventable newborn mortality, Every Newborn Action Plan, was launched in July 2014 under the "Every woman, every child" movement.

22. Working with local and international partners, the Global Polio Eradication Initiative has reduced the incidence of polio by more than 99 per cent since its launch in 1988, and the number of countries with endemic polio has fallen from 125 to 3. At the end of 2013, endemic transmission remained only in Afghanistan, Nigeria and Pakistan. India was removed from the list of polio-endemic countries at the beginning of 2012 and the country was certified polio free early in 2014. In 2012, there were 223 polio cases in five countries; in 2013, there were 407 cases in eight countries. The increase in cases is in large measure due to increasing levels of insecurity.

23. According to the Child Health Epidemiology Reference Group of the World Health Organization (WHO) and UNICEF, 58,000 newborns died from neonatal tetanus in 2010, a 93 per cent reduction from the late 1980s. In 2013, five additional countries were validated as having eliminated the disease.

24. As of December 2013, 34 of the 59 priority countries have achieved that goal. In addition, maternal and neonatal tetanus have been eliminated in 18 states in India, in all of Ethiopia except the Somali region and in 29 of 33 provinces in Indonesia.

25. Measles remains one of the leading causes of death among young children, and more than 95 per cent of deaths occur in low-income countries with weak health infrastructure. Since 2000, more than 1 billion children in high-risk countries have been vaccinated against the disease through mass vaccination campaigns — about 211 million children in 2013 alone. Global measles deaths fell by 78 per cent over the period from 2000 to 2012. It is estimated that this intensification of measles vaccination averted 13.8 million deaths and reduced the number of cases from 562,400 to 122,000 annually.

26. Following the 2008 call by the Secretary-General for universal access to malaria interventions, distribution of life-saving commodities was rapidly expanded in sub-Saharan Africa, the region with the highest burden. In the period from 2001 to 2012, it is estimated that 3.3 million malaria deaths were averted, 90 per cent of them in children under 5 years of age in sub-Saharan Africa, primarily as a result of scaling up malaria interventions.

27. Of the 103 countries that had ongoing malaria transmission in 2000, 59 are meeting the Millennium Development Goal target of reversing the incidence of malaria. Of these, 52 countries are on track to reduce their case incidence rates by 75 per cent, in line with the World Health Assembly and Roll Back Malaria targets for 2015. However, these 52 countries account for only 4 per cent (or 8 million) of the total estimated 226 million malaria cases annually worldwide. International targets for malaria will not be attained unless considerable progress is made in the 17 countries with the highest burden, which account for an estimated 80 per cent of malaria deaths.

28. The Secretary-General's Global Strategy for Women's and Children's Health notes the inequitable access to life-saving medicines and health supplies by women and children around the world and calls on the global community, through multi-

stakeholder partnerships and the "Every woman, every child" movement, to accelerate action to address the major health challenges facing women and children. The United Nations Commission on Life-Saving Commodities for Women and Children, part of the "Every woman, every child" movement, addressed the challenges outlined in the Secretary-General's Global Strategy. In 2012 the Commission put forward 10 cross-cutting recommendations for scaling up access to 13 life-saving commodities by women and children. Since 2013, a number of Technical Resource Teams have been established and are carrying the Commission's recommendations forward at the global and national levels, and is coordinated by a United Nations multi-agency Reproductive, Maternal, Newborn and Child Health Strategy and Coordination team.

29. In 2013, one in four children under the age of 5 across the globe had stunted growth, despite overall positive trends. Between 2000 and 2012, stunting prevalence declined globally from 33 per cent to 25 per cent, and the number of children affected fell from 197 million to 162 million. In 2012, 56 per cent of all stunted children lived in Asia and 36 per cent in Africa. Inadequate quality and frequency of infant and young child feeding is a major contributor: globally, less than 40 per cent of infants are exclusively breastfed, and less than half benefit from breastfeeding within the first hour of birth. An estimated 190 million children suffer from vitamin A deficiency and 293 million from anaemia. Children in 24 per cent of all households worldwide do not receive sufficient iodine, a necessary nutrient for brain development. The prevalence of anaemia is 48 per cent in pregnant women and 30 per cent in non-pregnant women, with the highest prevalence in Africa and South-East Asia.

30. The Scaling Up Nutrition Movement, which unites Governments, civil society, businesses and citizens, is the unifying focus for the global nutrition community in supporting nationally driven processes to reduce stunting and other forms of malnutrition. Since it was launched in 2010, 50 countries have joined. Each is working to increase people's access to affordable, nutritious food and to protect, promote and support exclusive breastfeeding up to 6 months of age and continued breastfeeding, together with appropriate and nutritious food, up to 2 years of age or beyond. They are also addressing other determinants of nutritional status, such as clean water, sanitation, health care, social protection, provision of a stimulating environment and initiatives to empower women. Partners in this work are the SUN United Nations system network, the United Nations system Standing Committee on Nutrition and the United Nations Reproductive, Educative and Community Health programme (REACH). The United Nations system network links normative and policy work with country-level coordination in support of national nutrition plans and joint United Nations efforts.

31. Among 50 countries with available trend data, 40 have posted gains in exclusive breastfeeding rates since 1995. Of those countries, 18 experienced increases of 20 per cent or more, illustrating that substantial improvement can be made and sustained through implementation of comprehensive, at-scale strategies. Yet globally, only 55 per cent of children aged 6 to 8 months receive timely introduction of solid, semi-solid or soft foods. Evidence from a few countries indicates that dietary quality and diversity are major issues.

32. Today, children in three quarters of households globally consume adequately iodized salt, protecting them from iodine-related brain damage. However,

consumption is not uniform across the regions. For example, only 50 per cent of households in the West and Central African region consume adequately iodized salt compared to over 90 per cent in East Asia and the Pacific.

33. Flour fortification remains an important tool to reduce folic acid and iron deficiencies and help prevent birth defects by improving levels of iron in women of childbearing age. In coordination with partners, alliances have been established among Governments and international agencies, the wheat and flour industries, and consumer and civic organizations. Currently, 78 countries fortify wheat flour, comprising 34 per cent of all flour produced. Home fortification using micronutrient powders, a relatively new and promising intervention to improve iron status and diet quality among children, has been scaled up in 62 countries. As of 2013, 16 countries are implementing it on a national scale.

34. Integrated child health events continue to assure high coverage of vitamin A supplementation in developing countries. Globally, 70 per cent of children aged 6 to 59 months were fully protected with the requisite two annual doses of vitamin A in 2013. In the countries of West and Central Africa over 80 per cent of children receive the two doses. While less than half of all reporting countries achieved the recommended levels of 80 per cent coverage in 2012, one half of all countries reporting high coverage were in sub-Saharan Africa.

35. Over the last two decades the water and sanitation sector has made significant progress. Between 1990 and 2012, 2.3 billion people gained access to an improved drinking water source, and almost 2 billion to improved sanitation facilities. The latest data show that 130 countries have met the Millennium Development Goal target for drinking water and 84 countries have met the sanitation target. However, more than 700 million people still lack access to improved drinking water, and challenges remain with regard to safeguarding the sustainability and safety of drinking water.

36. Globally, 2.5 billion people still lack access to improved sanitation, and 1 billion of them practice open defecation. If current trends continue, there will still be 2.4 billion without access to improved sanitation in 2015, and the world will miss the Millennium Development Goal target by more than half a billion people. In 46 countries, mostly in sub-Saharan Africa and South Asia, less than half the population has access to improved sanitation. Further, 82 per cent of the population practicing open defecation live in just 10 countries. Nevertheless, open defecation has declined in all developing regions, from 31 per cent in 1990 to 17 per cent in 2012.

37. Among the countries that have made good overall progress, national averages often hide significant disparities between rural and urban areas and between the rich, poor and marginalized. Between 1990 and 2012 for example, 72 per cent of the 1.6 billion people gaining access to piped water on premises (the highest standard) lived in urban areas; and 90 per cent of the global population that still rely on untreated surface water live in rural areas. Similarly, 70 per cent of the population without access to improved sanitation live in rural areas, as do 90 per cent of the population practicing open defecation.

38. In the last decade compelling evidence has emerged on the importance and impact of the child's early years on his or her entire future. Yet at least 200 million children under 5 years of age fail to reach their potential in cognitive and

socioemotional development because of four causes: malnutrition that leads to stunting; iodine and iron deficiencies; and inadequate stimulation. Recent research emphasizes the importance of these risks. It also strengthens the evidence for other risk factors including intrauterine growth restriction, malaria, lead exposure, HIV infection, maternal depression, institutionalization and exposure to societal violence. In addition, the research identifies protective factors such as breastfeeding and maternal education.

39. For the first time, in 2013, early childhood development reporting was made possible through the Holistic Early Childhood Development Index. It indicates that globally only 63.6 per cent of children under 5 years of age are developmentally on track. The number for the poorest children is much lower: only 58.1 per cent are on track. Across the 31 countries analysed as part of the fourth round of multiple indicator cluster surveys, only one fifth (20.8 per cent) of young children have access to early childhood education programmes. In addition, many young children with disabilities and developmental delays remain unidentified and invisible, failing to receive rehabilitation services during the critical years.

40. Also in 2013, the Care for Child Development package was rolled out through an inter-agency agreement with global partners. The International Paediatric Association adopted a resolution endorsing this model, and 16 inter-agency partners endorsed a resolution on the package, pledging support in technical expertise, coordination and financial resources to enhance roll-out efforts. Additionally in 2013, UNICEF launched the global Early Childhood Peace Consortium to address the needs of young children and their families in conflict and post-conflict settings and to promote peacebuilding. Early in 2014, UNICEF spearheaded a global discussion on translating into practice and programming the latest neuroscientific evidence on brain development, which has profound implications for early childhood development.

B. Providing quality education

41. The commitment to provide quality education was made nearly 25 years ago, at the first Education for All Conference (Jomtien, Thailand) and was reinforced through Millennium Development Goals 2 and 3. It is now clear that these Goals will be missed by a wide margin. Although the number of children out of school was cut in half between 1999 and 2011, over 57 million children of primary-school age still remain out of school. More than half of them are in sub-Saharan Africa, where the primary net enrolment rate increased to 77 per cent in 2011 from 58 per cent in 1990, but there has not been any appreciable gain since 2007. South and West Asia had the highest gains in reducing the number of children out of school, contributing more than half the total reduction. However, the region's primary net enrolment rate stands at 89 per cent, leaving over 12 million children out of school.

42. Progress in guaranteeing that children stay in school has also stalled since 2009, when primary completion rates peaked at about 90 per cent for developing countries as a whole. Estimates show that a quarter of all out-of-school children enter school late and become more likely to drop out, and that another quarter drop out before completing basic education. Dropout rates are highest in sub-Saharan Africa and South Asia, where only 70 per cent and 88 per cent, respectively, reach the last grade of primary school.

43. About half of the children out of school are living in conflict-affected countries, an increase from 42 per cent in 2008. Of these children, 95 per cent live in low- and lower-middle-income countries, and 55 per cent of the total affected are girls. Many children do not go to school owing to inherent disadvantages, such as disabilities. The estimated number of children with disabilities ranges from 93 million to 150 million, and many of them are likely to be denied a chance to go to school.

44. Inequities in education persist, based on factors such as gender, poverty, location and deeply ingrained social and cultural barriers. Often, the most disadvantaged children are those facing compound barriers and subtle and hidden forms of social exclusion. One of the most disadvantaged groups are girls — over 31 million are out of school, half of whom are expected never to enter school. An estimated 73 per cent of girls who are out of school live in sub-Saharan Africa and South and West Asia. Estimates show that, given the current trend, boys from rich families should reach universal primary education by 2030 in 56 of 74 low- and middle-income countries, compared to only 7 countries for girls from poor families. In sub-Saharan Africa, the richest boys will achieve universal primary completion in 2021, while the poorest girls will not do so until 2086.

45. Similar patterns of disparities persist at the secondary education level, often on a greater scale, given that it still remains neither free nor compulsory in many countries. Between 2000 and 2011, lower secondary completion rates increased by 66 per cent in low- and middle-income countries, with most progress in the East Asia and Pacific region, where rates doubled to 99 per cent. In sub-Saharan Africa, however, the completion rate is only 26 per cent. The transition from primary to lower secondary school is particularly difficult for girls, with only about 56 per cent of countries expected to achieve gender parity in lower secondary education by 2015.

46. The most pressing agenda facing achievement of education for all is addressing the learning crisis that has resulted from lack of attention to true measures of the quality of education and failure to reach the most disadvantaged children. Globally, an estimated 250 million of 650 million primary-school-age children are not acquiring even the most basic literacy and numeracy skills. Of these, 130 million are in school, suggesting serious gaps in the quality of education. According to the *Education for All Global Monitoring Report 2013/2014*, this translates into a loss of an estimated $129 billion a year. A total of 37 countries are losing at least half the amount spent on primary education because children are not learning. Reasons for low levels of learning are numerous and systemic, ranging from an insufficient number of qualified teachers to inadequate materials and infrastructure and lack of appropriate standards and tools to identify, measure and promote learning. Disadvantaged children are the most likely to suffer from reduced learning achievement, as their learning is impeded by factors such as limited access, chronic malnutrition, poor health and discrimination.

47. A key strategy to facilitate children entering school at the right age, remaining in school and learning is to provide access to quality pre-primary education, which fosters a strong foundation in the early years. Since 2000, pre-primary education has expanded considerably, from a gross enrolment ratio of 33 per cent in 1999 to 50 per cent in 2011. However, half the children aged 3 to 6 remain unreached, and progress has been unevenly distributed: only 18 per cent of children in sub-Saharan Africa

and 17 per cent in other low-income countries are enrolled in some form of pre-primary education. A wide gap in enrolment rates also exists between rich and poor children, owing to limited government provision and the cost of private pre-primary education. Thus, expanding quality pre-primary education is one of the most critical responses to tackling the dual challenges of equity and learning.

48. Reaching the remaining out-of-school children requires a concerted effort to improve systems and services and to tackle the diverse, often deeply ingrained barriers to quality education faced by marginalized children. It is also important for these children to enter school at the right age, which increases their chances of completing school and learning. This calls for investments in innovative solutions and a focus on measuring and promoting learning achievement. The gender equality components of the Millennium Development Goals also necessitate the access of girls to safe and protected schooling environments, free of discrimination and violence, all of which continue to be critical challenges. Unlocking the potential of teachers who are trained, motivated and supported by strong education systems can greatly enhance their ability to identify children in need and support their learning. Appropriate curriculum and assessment systems can also support teachers in devoting attention to the success of children in the early grades, when the most disadvantaged are at highest risk of dropping out.

49. Insufficient financing may be another major obstacle to achieving the goals of quality education for all. Overall commitments to basic education dropped by 35 per cent between 2009 and 2011, which resulted in a 16 per cent reduction in disbursement to basic education between 2009 and 2012. This brought overall aid to education back to the 2008 level, and aid reductions are expected to continue in coming years. Globally, there is a financing gap of $26 billion in achieving quality basic education by 2015. In humanitarian situations, education receives only 1.4 per cent of all humanitarian aid. To provide for continued progress, increased external and domestic resources for education are vitally needed, as well as more diversification of funding and more attention to efficiency and equity.

50. The role of the Global Partnership for Education is ever more critical in mobilizing political support and resources and bringing partners into focused efforts to achieve equitable, quality learning for all. UNICEF will continue to be a key partner, both through engagement and leadership in the Board of Directors and through country-level coordination and implementation of programmes to advance strategic priorities.

51. Through the Secretary-General's Global Education First Initiative, the final push for progress by 2015 also continued in 2013, including through Learning for All Ministerial Meetings, Education Cannot Wait campaigns and mobilization of the Initiative's Youth Advocacy Group. The United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNICEF have led the worldwide consultations on the post-2015 agenda in education, which is reinforcing the need to focus on learning and equity and for expansion of attention to include pre-primary and secondary education. Global efforts to advance the "access plus learning" agenda are becoming more prominent, through strategic engagements in key partnerships such as the global Learning Metrics Task Force.

52. In 2013, the growing number and scale of conflicts and natural disasters affected millions of children in the Central African Republic, Mali, the Philippines, South Sudan and the Syrian Arab Republic and neighbouring countries, among

others. Through the efforts of UNICEF, close to 3.6 million children were able to access formal and non-formal education opportunities in safe, protected spaces. Emergency response through advocacy, preparedness planning, risk assessments and back-to-school campaigns at various levels will continue to be supported. UNICEF will also continue its leadership in 57 country-level education clusters and in the Global Coalition to Protect Education from Attack.

C. Protecting against abuse, exploitation and violence

53. Governments are increasingly evaluating their child protection systems and prioritizing areas that need strengthening. By the end of 2013, 104 countries had clarified the nature of their systems and areas requiring attention, and 74 of them now have results reflected in government budgets, policy papers or legislation, which will benefit approximately 690 million children. For example, in 2006, 35 countries had an alternative care policy; by 2013, this had risen to 62 countries, providing scope to protect potentially 455 million children. In 2013, 51 countries addressed policies, legislation and strategies. The result was passage of at least 12 important national laws related to justice for children, potentially affecting 410 million children.

54. There is now greater understanding of the dynamics of social norms that result in violence, exploitation and abuse and of what works to promote positive norms that seek to end harmful practices. In the 2013 report of the Special Representative of the Secretary-General on violence against children it was noted that since 2006 there has been an increase of almost 50 per cent in the number of countries with policies in place to prevent and address violence.

55. Global attention was further enhanced through the launching of the #End Violence against Children initiative. Formal launches were held in more than 60 countries and social media actions took place in over 190 countries.

56. More than three years into the Secretary-General's campaign for universal ratification of the Optional Protocols to the Convention on the Rights of the Child, national commitment to end child sexual abuse and exploitation is sustained across all regions. The Optional Protocol on the sale of children, child prostitution and child pornography has been ratified by 86 per cent of all States Members of the United Nations, with four more ratifications in 2013. The Optional Protocol on the involvement of children in armed conflict has been ratified by 80 per cent of the Member States, with two more ratifications in 2013.

57. While new global estimates show that child labour has declined by one third since 2000, worldwide approximately 168 million children aged 5 to 17 years still remain engaged in this practice. Scaling up interventions to eliminate child labour remains a key priority. In 2013, UNICEF issued a revised global framework on child labour, which seeks to improve understanding of its underlying causes and to address the links between those causes.

58. The Joint Programme on Female Genital Mutilation and Cutting, co-sponsored by the United Nations Population Fund (UNFPA) and UNICEF, marked its fifth year in 2013. An estimated 2,538 communities in 8 countries now adhere to public declarations to abandon that practice. Also in 2013, UNFPA and UNICEF launched the most comprehensive analysis on female genital mutilation and cutting to date

and released an evaluation report on the Joint Programme. Recommendations were disseminated globally to a wide variety of stakeholders and informed the refinement of the programmatic strategy for a second phase (2014-2017).

59. To generate results at scale and invigorate the global movement to end child marriage, UNICEF is intensifying efforts in eight countries with medium to high prevalence rates that are poised to make progress. These efforts help buttress the wider United Nations response that includes UNFPA, UN-Women, WHO and the World Bank, among others. Further, the Human Rights Council and the General Assembly adopted procedural resolutions on child marriage, calling for a report of the Secretary-General on child, early and forced marriage and a debate at the sixty-ninth session of the General Assembly.

60. In 2013, UNICEF responded to the protection needs of children in more than 50 countries affected by armed conflict and natural disasters. These included three large-scale (Level 3) emergencies, in the Central African Republic, the Philippines and the Syrian Arab Republic. Global estimates indicate that 13,500 children separated during armed conflict or natural disasters were reunited with their families during the year. Approximately 2.5 million children were able to access safe community spaces for socializing, play and learning. More than 7,360 children associated with armed forces or groups were reunited with their families and reintegrated into their communities. In addition, approximately 30,000 women and children who had experienced gender-based violence were reached, of whom 30 to 40 per cent were children, the majority of them girls.

D. Combating HIV and AIDS

61. Globally, an estimated 35.3 million people (32.2 million-38.8 million) were living with HIV in 2012. Approximately 2.1 million (1.7 million-2.8 million) of them were aged 10 to 19, of whom 57 per cent were female. There were about 2.3 million (1.9 million-2.7 million) new HIV infections globally, of which 260,000 were in children under 15 years of age. About one third of all new infections (780,000) occurred among young people aged 15 to 24 years, and of these 300,000 were among adolescents aged 10 to 19.

62. Steadily expanding coverage of the most effective antiretroviral medicines, together with new approaches to providing them, offer hope for meeting the goals of the Global Plan towards the Elimination of New HIV Infections in Children by 2015 and Keeping Their Mothers Alive. This effort also contributes to the broader maternal and child survival goals of the *2012 Progress Report on Committing to Child Survival: A Promise Renewed*, under the umbrella of the "Every woman, every child" movement. In the 22 countries with the highest rates of mother-to-child transmission of HIV, overall mother-to-child transmission rates have declined, from an estimated 26 per cent in 2009 to 17 per cent in 2012. The number of children under age 15 who were newly infected in those countries fell by 36 per cent, from 360,000 in 2009 to 230,000 in 2012. In that period, seven countries halved new HIV infections among children. The vast majority of new HIV infections among children from birth to 14 years were in Eastern and Southern Africa (130,000) and West and Central Africa (98,000), with many fewer in South Asia (15,000) and East Asia and the Pacific (7,900). All other regions reported fewer than 3,000 new infections each in 2012.

63. One of the core targets of the Global Plan is to provide antiretroviral therapy to 90 per cent of the world's pregnant women living with HIV by the end of 2015. This goal is now within reach. In the 22 Global Plan countries with the highest rates of mother-to-child transmission, 62 per cent of pregnant women living with HIV received prophylaxis in 2012, compared with 57 per cent in 2011.

64. While new HIV infections among children are falling faster than at any other time in the history of the epidemic, the pace will have to be accelerated to achieve the 2015 target of a 90 per cent reduction compared to the 2009 baseline. While, as noted, the overall coverage of antiretroviral therapy for prevention of mother-to-child transmission in low- and middle-income countries reached 62 per cent in 2012, there was considerable variation across regions. In Eastern and Southern Africa, where the HIV burden is greatest, three quarters of pregnant women have access to that therapy. In Central and Eastern Europe and the Commonwealth of Independent States, coverage is reported as very high (greater than 95 per cent), as it is in Latin America (88 per cent) and the Caribbean (58 per cent to 95 per cent).

65. Globally, inequities persist in coverage and access to HIV and health services for children and pregnant women living with HIV. The Monitoring Results for Equity Systems has identified barriers faced by women and their partners and infants, including access to early infant diagnosis and better treatment formulations, retention in antiretroviral therapy services and appropriate support to promote exclusive breastfeeding. While global data on antiretroviral therapy coverage during the breastfeeding period are limited, it is estimated that in 2012 nearly half of mothers in 21 Global Plan countries in Africa did not receive treatment during the breastfeeding period. Up to about half of all new infections in children in sub-Saharan Africa are estimated to have occurred as a result.

66. The pace of scaling up access to antiretroviral therapy for children under 15 years is only half that of adults. For children, access increased 14 per cent from 2011 to 2012, compared to 20 per cent for adults. In low- and middle-income countries, overall antiretroviral therapy coverage for children under age 15 has consistently been around half that for adults — 34 per cent for children compared to 64 per cent for adults in 2012. Only 39 per cent of children in low- and middle-income countries were estimated to have access to early infant HIV diagnosis testing within the recommended two months of birth in 2012. In low- and middle-income countries, only 58 per cent of pregnant women living with HIV received antiretroviral therapy for their own health in 2012, compared with an estimated 64 per cent of all adults who received antiretroviral therapy that year.

67. Alarming new data published in December 2013 in the *Sixth Stocktaking Report on Children and AIDS* show that AIDS-related deaths have increased in the past seven years among children aged 10 to 19 years — the only age group registering a growing death rate. While AIDS-related deaths overall have dropped by 30 per cent globally since 2005, among adolescents they have increased by 50 per cent. In 2012, over 90 per cent of those AIDS-related deaths among adolescents (97,000 of 110,000) occurred in sub-Saharan Africa. They include both adolescents who were infected through mother-to-child transmission and older adolescents —primarily girls — who were infected through sexual transmission early in adolescence.

68. Coverage of HIV testing and counselling is low among adolescents, especially among at-risk populations in most parts of the world. While access and coverage

vary greatly by country, survey data from 2008-2012 in sub-Saharan Africa indicated that fewer than one in five girls aged 15 to 19 were aware of their HIV status.

69. In 2012, approximately two thirds of new HIV infections in adolescents aged 15 to 19 affected girls, mainly in sub-Saharan Africa. In three countries in this region more than 80 per cent of adolescents aged 15 to 19 years who were newly infected with HIV in 2012 were girls: Gabon (89 per cent female), Sierra Leone (85 per cent female) and South Africa (82 per cent female).

70. Worldwide, disproportionately high rates of HIV prevalence are reported among adolescent males who have sex with other males, adolescents who inject drugs and sexually exploited adolescents. According to one of the few reports on the subject, more than 95 per cent of new HIV infections in adolescents in Asia and the Pacific were reported to occur in adolescents belonging to "key populations" — people whose behaviours put them at considerable risk of HIV infection and whose young age renders them particularly vulnerable. In Pakistan, where injecting drug use is a key driver of the epidemic, studies indicate that HIV prevalence more than tripled between 2005 and 2011, from 11 per cent to 38 per cent.

71. Social protection has already proved to have an impact not only in supporting children and families already affected by HIV but also in preventing HIV and improving treatment and care outcomes. Social protection programmes, particularly cash transfers, appear to be rapidly expanding, with some estimates suggesting the number has doubled in Africa — from 120 programmes implemented between 2000 and 2009 to about 245 programmes in 2012. In 2012 alone, cash transfer programmes received an estimated $10 billion in support. However, efforts to address the needs of children living with HIV or living in households affected by HIV through comprehensive protection, care and support interventions have not achieved broad coverage. Economic and psychosocial support is particularly important for the estimated 17.8 million children (16.1 million-21.6 million) who have lost one or both parents to AIDS.

72. For the first time in the history of the HIV epidemic, the global community has accumulated the knowledge, experience and tools to achieve an AIDS-free generation. That means a generation in which all children are born free of HIV and remain so for the first two decades of life, from birth through adolescence, and that children living with and affected by HIV have the treatment, protection, care and support they need to survive and thrive.

IV. The way forward

73. The post-2015 development agenda will provide the framework for global development priorities for the coming decades. This is a once-in-a-generation opportunity to define a world that is fit for all children and to demonstrate the centrality of children in all aspects of sustainable development. For over a decade, the Millennium Development Goals have been a powerful and unifying force in pursuing global development objectives. However, they have fallen short in three critical areas for children: participation and inclusion in creating and implementing the new framework; addressing inequalities and promoting equity; and child protection. Formulation of the sustainable development goals provides an opportunity to address these challenges decisively.

74. The implementation of newly approved strategic plans and global initiatives for the period 2014-2017 for the United Nations system — UNICEF, the United Nations Development Programme, UNFPA, UN-Women, the Joint United Nations Programme on HIV/AIDS, UNESCO, WHO, the World Food Programme and others — also has the potential to drive significant change. Each of these entities addresses issues that shape the lives of children, and the fact that many are putting more and more emphasis on equity is increasing the momentum to improve the lives of the most disadvantaged citizens, especially children. Furthermore, the quadrennial comprehensive policy review is helping these organizations and other parts of the United Nations system operate more effectively and efficiently, including by promoting joint work and leveraging synergies across the organizations.

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Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

Situation of human rights defenders

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the situation of human rights defenders, Mr. Michel Forst, in accordance with General Assembly resolutions 66/164 and 68/181 and Human Rights Council resolutions 16/5 and 25/18.

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Report of the Special Rapporteur on the situation of human rights defenders

Summary

The present report, which is the first by the Special Rapporteur, is essentially focused on the manner in which he approaches his mandate and on the vision and priorities that he has established for the coming years. The Rapporteur analyzes the terms of his mandate, as set forth in Human Rights Council resolution 16/5 and extended in resolution 25/18; describes the working methods of the mandate and the techniques used; and presents a brief overview of the activities that he has undertaken in the course of the first weeks of his mandate.

The Special Rapporteur then gives details of his vision for the mandate and the priorities that he has set himself for the coming years. Thus, he intends to work on a thorough analysis of trends and problems as well as on identification of the challenges to which human rights defenders are the most exposed, notably the issue of the legal framework within which they work, and the hindrances that certain national legislations place in the way of their legitimate activities of promotion and protection of human rights, so as to contribute to a more effective protection for them. The Special Rapporteur intends to strengthen his cooperation with other mandate holders and regional mechanisms, especially through exploring the possibility of developing greater synergies and new joint actions. He plans to ensure better follow-up to communications and country visits, in particular by exploring the possibility of new working methods. He hopes to be in a position to contribute to the development and distribution of good practices among States, all stakeholders and the defenders themselves.

The dissemination of the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms will be a priority objective to which the Special Rapporteur will pay very close attention. The issue of enhancing the visibility of the situation of human rights defenders will be an important thrust of his work, to which end he intends to utilize all the resources offered by modern communication techniques. Finally, he plans also to work on the issue of the reprisals to which defenders are exposed in their interaction with the United Nations, regional organizations and other stakeholders, and to take part in combating any impunity enjoyed by the perpetrators of such reprisals.

I. Introduction

1. The present report is the first submitted to the General Assembly by the current Special Rapporteur on the situation of human rights defenders and the fourteenth submitted by the mandate holder on human rights defenders since the establishment of the mandate in 2000. It is submitted pursuant to Human Rights Council resolution 25/18 and General Assembly resolution 66/164.

2. The work of the Special Rapporteur will also be guided by the thematic resolutions, in particular General Assembly resolution 68/181 and Human Rights Council resolutions 22/6 and 13/13.

3. The overriding spirit of this first report is one of humility in the face of the scale of the task ahead of the Special Rapporteur and a sense of his responsibility towards human rights defenders. The Special Rapporteur wishes to stress here how important it is that the special procedures mandate holders should be able to act with independence. In his case, such independence means that he is primarily and ultimately responsible for the decisions he will adopt and the actions he will take in performing the mandate entrusted to him, for which he will be accountable before the members of the Human Rights Council.

4. The Special Rapporteur also wishes to underline how much he has inherited from the founding spirit of the preceding two mandate holders, Ms. Hina Jilani and Ms. Margaret Sekaggya, who succeeded in providing this mandate with the scale and visibility needed to help establish the legitimacy and recognition of the work of human rights defenders. He intends to be guided by their work as he continuously seeks to develop highly innovative working methods, such as will contribute to a more effective protection of the defenders.

5. The Special Rapporteur has elected to focus this report on his vision for the manner in which he intends to perform the mandate entrusted to him by the Human Rights Council and on the chief priorities which he will pursue during the opening years of carrying out that mandate.

6. This choice he has made is intended in the first place to provide clear information to States and to other stakeholders on the interpretation that he places on the terms of reference of the mandate entrusted to him, and secondly to set forth, in the latter part of the present report, the principal lines of action he will pursue.

7. The Special Rapporteur intends in particular to ensure widespread awareness and ownership of the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms.

8 He intends to join with others in enhancing his knowledge and application of good practices.

9. The Special Rapporteur hopes to be able to establish conditions that will enable him to have closer interaction with governments in following up on communications and dealing more effectively with the matter of impunity.

10. In the communications area, his objective is to bring about greater visibility for and enhanced knowledge of the role played by defenders.

11. The Special Rapporteur has noted with concern the resurgence of reprisals against defenders and intends to make a contribution to awareness-raising among all actors as to the political responses to be applied to this issue.

12. He will specifically monitor at-risk groups in order to be able to put forward a more appropriate response to the problems encountered by them.

13. Finally, the Special Rapporteur intends to strengthen cooperation and to develop greater synergy with other mandate holders, regional mechanisms and all stakeholders.

II. Mandate

14. The Human Rights Council examined the mandate relating to the situation of human rights defenders and extended it in its resolutions 7/8 and then 16/5, stating the responsibilities of the position of mandate holder in the following terms:

"(a) To promote the effective and comprehensive implementation of the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms through cooperation and constructive dialogue and engagement with Governments, relevant stakeholders and other interested actors;

"(b) To study, in a comprehensive manner, trends, developments and challenges in relation to the exercise of the right of anyone, acting individually or in association with others, to promote and protect human rights and fundamental freedoms;

"(c) To recommend concrete and effective strategies to better protect human rights defenders through the adoption of a universal approach, and to follow up on these recommendations;

"(d) To seek, receive, examine and respond to information on the situation and the rights of anyone, acting individually or in association with others, to promote and protect human rights and fundamental freedoms;

"(e) To integrate a gender perspective throughout the work of his/her mandate, paying particular attention to the situation of women human rights defenders;

"(f) To work in close coordination with other relevant United Nations bodies, offices, departments and specialized agencies, both at Headquarters and at the country level, and in particular with other special procedures of the Council;

"(g) To report regularly to the Human Rights Council and the General Assembly."

15. The Special Rapporteur confirms that Human Rights Council resolution 25/18 will form the roadmap of his mandate, subject to its being read in conjunction with other Council resolutions, notably the preambular part of resolution 22/6 in which the Council draws attention to the legal framework within which human rights defenders work, and the hindrances that certain national legislations place in the way of their legitimate activities of promotion and protection of human rights.

16. The Special Rapporteur intends to carry out specific work in those areas and to return to the Human Rights Council and the General Assembly with relevant recommendations.

III. Working methods

17. The Special Rapporteur will base his approach largely on the working methods drawn up by the preceding two mandate holders, observing the provisions of the Code of Conduct for Special Procedures Mandate-holders of the Human Rights Council appended to Human Rights Council resolution 5/2 and as described in the Manual of Operations of the Special Procedures of the Human Rights Council adopted in June 2008 at the fifteenth annual meeting of mandate holders responsible for implementing the special procedures of the Human Rights Council.

18. However, he also plans to explore the possibility of developing new working methods which in some cases will be more appropriate to the advances in communication techniques, while still observing the rules applicable to mandate holders.

19. At the time of drafting of the present report, the Special Rapporteur is attempting to set up a series of regional consultations which will enable him to meet defenders in the field. The main objective of such consultations will be to work with them on current trends, the threats facing them and the specific needs applicable to certain at-risk categories of defenders. The aim will also be to discuss with them their perception of the effectiveness of the current protection programmes and mechanisms or the measures taken by States which hamper defenders' freedom of action. These regional consultations will also make it possible to verify the effectiveness of national measures taken by some governments to protect defenders, in particular national legislation and guidelines on the protection of human rights defenders, developed at international or national level.

A. Communications and press releases

20. Since taking office, the Special Rapporteur has been regularly sending communications to governments on the situation of human rights defenders and on the legislation, protection mechanisms and other topics relating to the defenders, as these are supplied to him from various sources. Such communications are very often undertaken jointly with the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, the Special Rapporteur on the rights to freedom of peaceful assembly and of association, or other mandate holders.

21. He intends to intensify his cooperation with other mandate holders, especially with those holding a country mandate, and to examine with them the opportunities for joint or coordinated actions on the situation of the defenders in the countries for which they are responsible.

22. Similarly, the Special Rapporteur intends to study the possibility of launching joint actions with regional human rights mechanisms in Africa, the Americas and Europe.

23. He wishes to draw attention here to the importance of the work undertaken by the regional networks of defenders and also by the main international human rights organizations, which represent a very valuable source of information and will allow him to cross-reference and verify the information or allegations that he receives.

24. Such communications to governments take varying forms depending on the nature of the allegations received or the urgency of the situation. They represent the principal form of protection that the mandate holder is able to provide to the defenders.

25. Pursuing the spirit of transparency and dialogue with governments that guided the work of his two predecessors, the Special Rapporteur will continue to send communications to the relevant governments, as part of a coordinated effort to warn of or prevent human rights violations, protect human rights defenders, study alleged cases of violation and call on governments to bring those responsible to justice.

26. He intends to upgrade the tracking of communications which too often do not elicit a response, or not an adequate one, from certain governments. He intends, assisted by institutional partners, to undertake a more systematic quantitative and qualitative analysis of the communications issued and the responses received, in order to be able to provide information to States and to draw jointly with them whatever conclusions appear to be necessary.

27. He welcomes the declaration by Honduras during the twenty-sixth session of the Human Rights Council on behalf of the Group of 38 States on cooperation with the special procedures mandate holders and follow-up to communications, and recommends that States should respond better to the communications sent to them on situations concerning human rights defenders.

B. Country visits

28. Country visits constitute for all special procedures mandate holders a unique way of obtaining a better understanding of the reality of the countries and meeting government representatives and other stakeholders, especially human rights defenders.

29. The Special Rapporteur is aware of the workload that such missions impose on the authorities of the destination countries and wishes at this point to thank the governments that have issued invitations or welcomed a request to visit their country. He notes that, in order for him to obtain a better measure of the situation, his visits must be long enough to allow him to travel in the field, away from the national capital, in order to be able in particular to visit the defenders working in the more remote regions.

30. The Special Rapporteur intends to increase the frequency of such missions and he will send, or reissue, requests to visit several countries in a position to receive him officially. He hopes that his requests will be met with a prompt response which will make it possible for him to construct a short- and medium-term work plan.

31. As he is aware of the importance of the recommendations addressed to governments and very conscious of the need to follow up on them more systematically, the Special Rapporteur also intends to conduct follow-up missions to the countries already visited by the preceding mandate holders. He also intends,

when such action will be relevant and useful, and with the agreement of the States concerned, to explore the possibility of using visits planned to attend seminars or other meetings to meet the authorities of the country and to examine with them and other stakeholders the extent to which the recommendations made to them have been acted on.

C. Communication of information and thematic studies

32. The Special Rapporteurs regularly report to the Human Rights Council and the General Assembly, and the Special Rapporteur has read very attentively and with great interest the reports of his two predecessors which contain a large number of recommendations or suggestions which the Human Rights Council has examined within the scope of interactive dialogues. He intends to continue this work in order to be in a position to inform the Human Rights Council and the Assembly of the development of trends and threats on a regional or international scale.

33. In addition to his reports on the communications sent to governments or received from them and on the missions undertaken in countries, he will be involved in spheres of activity which will amplify the volume of knowledge accumulated by the earlier mandate holders. He will study new areas of analysis which will yield a deeper understanding of the Declaration on Human Rights Defenders, the many different aspects of their work and the difficulties they have to overcome.

34. The Special Rapporteur considers that the 2006 report of the former Special Representative of the Secretary-General on human rights defenders (E/CN.4/2006/95/Add.5) is a tool which should be reexamined and updated. The importance of country profiles for tracking the situation of human rights defenders has been widely recognized and this tool would benefit from a wider distribution once it has been updated. The Special Rapporteur is conscious of the amount of work and resources that that would involve, beyond his reach at the present time, and is counting on the support of States to make it possible to for him to carry out this activity.

IV. Activities

35. This section contains an overview of the activities undertaken by the Special Rapporteur in the period between his taking up his position, on 2 June 2014, and the finalization of the present report on 31 July.

36. The Special Rapporteur has launched a number of appeals and sent communications to governments on the situation of human rights defenders, as already described in the present report.

37. He took part in a meeting in Bern on 10 and 11 June, organized by the Swiss presidency of the Organization for Security and Cooperation in Europe (OSCE), on the occasion of the launching of the Orgenization's guidelines on the Protection of Human Rights Defenders.

38. On 13 June, he undertook a series of consultations with defenders who were in Geneva for the twenty-sixth session of the Human Rights Council.

39. In the same session of the Council, he took part in a side event in Geneva entitled "From threats to opportunities: Business and human rights defenders" organized by the International Service for Human Rights and the Legal Resources Centre of South Africa.

40. He took part in a meeting in Brussels on 17 June organized by the Permanent Mission of Ireland to mark the tenth anniversary of the European Union Guidelines on Human Rights Defenders, and also had consultations with representatives of the European Union.

41. The Special Rapporteur has prepared a series of regional consultations with human rights defenders, to take place in the coming weeks and months. These will allow him to penetrate deeper into his mandate and steer his activities in the years ahead. His future reports to the Human Rights Council and the General Assembly will inform them of the outcome of the regional consultations, which will undoubtedly have an impact on the performance of his mandate.

42. He has met various countries' Permanent Representatives to the United Nations in Geneva in order to discuss with them issues related to the performance of his mandate.

43. With his team and with other special procedures mandate holders he has held discussions on possible synergies and cooperation to be considered for the future.

V. Vision and priorities

44. This section examines the manner in which the Special Rapporteur envisages performing the mandate that has been entrusted to him. It acts as a roadmap for the activities ahead of him in the coming months and years.

A. Proposing a thorough analysis of trends and problems

45. The Special Rapporteur observes that, like his predecessors, he will be able to be more effective in fulfilling his primary task of supporting the work of human rights defenders and contributing to their visibility and protection if he remains abreast of the trends and the constants in this field.

46. For that reason, he is starting his mandate with a series of regional consultations, during which he intends to meet defenders and analyze together with them the national and regional trends, the threats against certain specific groups, the reprisals taken against them and the methods of protection developed in recent years, in order to evaluate their relevance and perhaps have them developed further on a case-by-case basis or more systematically.

47. Over and above the consultations with human rights defenders, the Special Rapporteur intends to make use of various opportunities, notably his travel to Geneva or to national capitals, to meet State representatives and listen to their observations and their points of view on developing trends, the effectiveness of the protection programmes and mechanisms, the impact of national legislation on the protection of human rights defenders or, as the Human Rights Council says in its resolution 25/18, the fact that, in some instances, national security and counter-terrorism legislation and other measures, such as laws regulating civil society

organizations, have been misused to target human rights defenders or have hindered their work and endangered their safety in a manner contrary to international law, and the need to prevent and stop the use of legislation to hinder or limit unduly the ability of human rights defenders to exercise their work. That is one of the issues on which the Special Rapporteur will work in the near future.

B. Identifying the challenges of the defenders who are the most exposed in order to contribute to more effective protection for them

48. In the course of the initial consultations held in Geneva and Brussels and the bilateral discussions which he has been able to have with representatives of regional networks of defenders, the Special Rapporteur has been struck, among other issues, by how frequently his attention has been drawn to the most exposed groups, such as those who are seeking to promote and protect economic, social and cultural rights or the rights of minorities; environmental defenders; defenders of the rights of lesbian, homosexual, bisexual, transsexual and intersex persons, female defenders and those who strive for the rights of women; defenders who work on issues of companies and human rights; those who work in an area exposed to an internal conflict or a natural disaster; defenders living in isolated regions; or those who work on past violations, who are especially targeted.

49. For several years, human rights defenders have been mobilizing for the protection promised by the Universal Declaration of Human Rights to be extended to the new threats hanging over human dignity. In this context they have been advocating for the protection of rights also to be guaranteed in the home or community setting, on the basis of their efforts to combat violence against women. They have been campaigning for multinational companies to be morally and legally responsible for any of their actions or omissions that deprive men and women of their fundamental rights. They have been mobilizing for universal access to primary education and to antiretroviral drugs to become fundamental rights rather than being considered as services dependent on charity or level of economic development.

50. All are frequently exposed to the same threats and attacks, but some of them are more exposed or more threatened, or are subject to particular forms of attack, notably denigration or intimidation campaigns, stigmatization, threats against their families, defamation, denunciation or mockery, or unfounded administrative complications.

51. That is also an issue which is raised constantly in the complaints and reports received on the situation of defenders, showing that certain defenders are even more exposed to specific risks related to their particular sphere of activity.

52. For that reason, the Special Rapporteur has decided to structure the discussions with defenders, to be held in the regional consultations, around the topic of specific issues relating to the most exposed groups, so as to provide input to his thinking and new protection and support mechanisms more in line with the need to protect those groups more specifically at risk.

53. Each of the future thematic reports and mission reports will contain a specific section dedicated to analyzing the development of trends and particular threats facing the most exposed groups.

54. The Special Rapporteur thus intends to explore in a more expansive manner the mandate of protection that has been entrusted to him and to go as far as possible in fulfilling that mandate to whatever extent appears to him to be necessary in order to provide information to the Human Rights Council and the General Assembly and, following the example of his predecessors, to pursue the development of new or increasingly sophisticated methods to contribute to the protection of the rights of the defenders.

C. Strengthening cooperation with other mandate holders

55. The Special Rapporteur has been struck by the number of cases relating not only to his own mandate on the situation of human rights defenders but also to the rights to freedom of peaceful assembly and association as well as the right to freedom of expression. Currently, all of the communications are ones issued jointly with other mandates, the majority of them having to do with the rights to freedom of peaceful assembly and association and with the promotion and protection of the right to freedom of opinion and expression.

56. Restriction of the right to freedom of assembly and association is often one of the earliest measures adopted by States to crack down on human rights defenders or to prevent them from promoting and protecting rights and freedoms. The recent reports submitted to the Human Rights Council by the Special Rapporteur on the rights to freedom of peaceful assembly and of association and the numerous complaints received show that the trend is steadily becoming more pronounced, and this is also one of the observations of the Human Rights Council in the preambular part of its resolution 25/18 renewing the mandate of the Special Rapporteur on the situation of human rights defenders. The Special Rapporteur intends to strengthen his cooperation with the mandate holder on the rights to freedom of peaceful assembly and of association and to propose new cooperative procedures.

57. Similarly, unwarranted restrictions on freedom of expression or opinion are often utilized by States to prevent defenders from expressing themselves or undertaking actions to protect and promote rights and fundamental freedoms.

58. This is the reason that the Special Rapporteur intends, while preserving the independence of his mandate, to broaden collaboration with the holders of the mandates closest to his own, in order to promote better protection for defenders and draw the attention of the international community to the methods employed by States to curb or prevent the activities of human rights defenders, and to propose processes of joint or coordinated action with these two mandates, which may possibly result, should it be appropriate, in activities or country visits with these two other mandate holders.

59. The Special Rapporteur is also envisaging the possibility of developing, as appropriate, a series of joint actions with other thematic mandate holders who are also dealing with cases of threats or attacks against human rights defenders or of violations of their rights.

60. He also intends, at an appropriate moment, to act more closely with country mandate holders in order to increase the effectiveness of the protection provided to defenders in the countries for which they are responsible, exploring with them the

possibility of making it a general practice to include in their reports a specific section on the situation of defenders, if such a practice would be appropriate.

D. Ensuring better follow-up to communications and country visits

61. The Special Rapporteur has been struck by the low number of responses coming from governments,[1] given the number of urgent appeals and well-documented written allegations. Also, even when responses are recorded they very often do not exactly cover the situation or file referred to, being sometimes couched in very general terms without real relevance to the gravity of the cases reported.

62. Similarly, at the time of initial consultations with defenders, the issue of the follow-up to files appeared to be of crucial importance. Few of the defenders knew whether the file they sent to the mandate holder had been received, and how their complaint had been dealt with. While safeguarding the necessary confidentiality regarding the data received and the use made of them, the Special Rapporteur considers that, at the least, a formal acknowledgement of receipt should be given to any person, any organization or any network sending in a complaint or calling on the mandate holder to take action. This should be done in strict observance of the code of conduct and of the confidentiality of the interactions between the Special Rapporteur and governments. He intends to study the matter jointly with the main partner organizations in order to confirm with them the procedures that would be desirable and applicable in such cases.

63. Follow-up is important given the need to avoid the risk of people's rushing headlong into multiple and repeated submissions of information, forgetting that the Special Rapporteur has taken action in the past on hundreds of cases, each of which tells an individual story that demands a specific response, silence being the worst possible response.

64. At the same time follow-up is important to demonstrate, through the recounting of cases which were positively resolved, the good practices that can be reutilized or duplicated to increase the likelihood of obtaining positive results in a larger number of occurrences. The Special Rapporteur therefore intends, when possible, to illustrate his reports with positive accounts showing the relevance or effectiveness of a good practice.

65. The Special Rapporteur intends to make the issue of follow-up one of the major thrusts of his activities, and intends to provide regular and detailed information to the Human Rights Council and the General Assembly on cases of non-response, while at the same time informing them regularly on the follow-up applied to communications.

66. If resources allow, he intends to undertake a scientific study on the follow-up to communications and on the impact of non-response from States on the situation of defenders, and also regularly to repeat his contacts with non-responsive States.

67. All stakeholders, to some degree or other, have a specific responsibility in the process of following-up on communications and files. This is above all a responsibility of governments, since they hold the primary responsibility for heading off human rights violations and threats and attacks against defenders.

[1] The average rate of responses from States is around 45 per cent.

Further, they also have the responsibility of combating impunity and bringing to justice those responsible for rights infringements.

68. In her report covering national institutions for promotion and protection of human rights (A/HRC/22/47), the previous mandate holder showed the beneficial role that they may play not only in following up on recommendations but also in the processing of individual files. The Special Rapporteur intends to call on national institutions accredited as "Category A" to be partners in following up on recommendations in general, and also in following up on individual files whenever that seems appropriate.

69. Follow-up to country visits will also be a major thrust of the Special Rapporteur's activities. He intends, subject to availability of resources and where possible, to intensify the number of follow-ups to country visits and meetings with authorities to hear their views on the action taken in response to urgent recommendations and appeals.

E. Promoting enhanced cooperation with all parties concerned

70. Numerous parties are involved in protection of defenders and promotion of the Declaration on Human Rights Defenders: the United Nations, regional mechanisms for protection of human rights defenders, national human rights institutions, non-governmental organizations, regional courts and the media.

71. The United Nations, as a whole, is an essential actor needed to participate to some degree or other in the protection of defenders at risk.

72. This applies especially to peacekeeping missions when they have a specific mandate on human rights, as is the case, for example, for the United Nations Office in Burundi, the United Nations Stabilization Mission in Haiti, or the United Nations Stabilization Mission in the Democratic Republic of the Congo. The Special Rapporteur intends to make contact with the heads of peacekeeping missions, as well as with the Department of Peacekeeping Operations, in order to present his mandate and discuss possible cooperation to ensure better protection of defenders facing internal unrest or post-conflict situations.

73. Similarly, relations with the United Nations country teams on the ground and with United Nations bodies and agencies could be strengthened to make their contribution to the protection of defenders more effective, subject to the characteristics of the mandates of each of them.

74. As well as the United Nations, however, regional organizations can and should play a role in protecting defenders. The preceding mandate holders initiated and developed high-quality relations with such mechanisms in Africa and the Americas.

75. The Special Rapporteur takes the view that the principle of subsidiarity must apply in the protection of defenders. It is primarily the role of States to protect them, in particular by developing relevant legislative or regulatory measures. Here, the Special Rapporteur intends to intensify his efforts to convince governments to develop specific national measures, following the example of Brazil, Colombia, Côte d'Ivoire and Mexico, and it is also his intention to hold a consultation and undertake a study on this subject, with the aim of demonstrating the effectiveness of

national mechanisms in the protection of defenders, or alternatively to reveal the measures to be taken to improve that effectiveness.

76. However, if States are falling short, then the regional mechanisms that exist should be able to intervene to ensure protection for defenders, where that is possible. Unfortunately, looking beyond Africa and the Americas, there are no such specific mechanisms in Europe[2] or Asia.

77. The Special Rapporteur was interested to attend the presentation of the OSCE's guidelines on the Protection of Human Rights Defenders, taking advantage of that meeting to initiate promising contacts with the Commissioner for Human Rights of the Council of Europe and the European Union Special Representative for Human Rights, both of whom requested him to arrange for coordination in Europe with their respective mandates.

78. The Special Rapporteur plans to initiate enhanced cooperation with regional mechanisms in order to undertake with them, as appropriate, concrete actions to bring about coordination between the international and regional levels. Such cooperation may take various forms, such as joint public appeals, shared missions or common publications in the media when this is desirable.

79. The previous Special Rapporteur showed in her report on the situation of human rights defenders (A/HRC/22/47) the specific role that national human rights institutions and the mediator can play in the area of promotion and protection of defenders.

80. The Special Rapporteur intends to strengthen his relations with national institutions, either individually or collectively, by working through their International Coordinating Committee or their regional networks, or directly at national level, not only to promote the Declaration on Human Rights Defenders but also to facilitate follow-up to communications.

81. The Special Rapporteur naturally also plans to pursue and develop the excellent relations he has with international, regional and national non-governmental organizations specializing in the protection of human rights defenders, in particular those who actually provide protection or relocation of defenders, observing the working rules applicable to special procedures mandate holders and the requisite independence of each of them.

82. The Special Rapporteur intends to develop his cooperation with regional courts[3] which, especially on the basis of new provisional measures, make it possible to ensure protection of defenders, particularly those who are threatened with refoulement or being deported to countries at risk. Numerous accounts received have shown the effectiveness of such measures, since States have an obligation to implement them and suspend such deportations.

83. Finally, in the context of cooperation with other stakeholders, the Special Rapporteur wishes to draw attention to the essential role played by the media and

[2] Although the Commissioner for Human Rights of the Council of Europe and the European Union Special Representative for Human Rights do have a mandate which partially covers the problems and issues relating to defenders of human rights.

[3] European Court of Human Rights, Inter-American Court of Human Rights, African Court of Justice and Human Rights and Court of Justice of the Economic Community of West African States.

social networks in the promotion of the Declaration on Human Rights Defenders and the effective protection of defenders. He has been made aware of numerous cases of journalists, notably those providing broadcast reports or written articles on human rights, whistleblowers and bloggers, and considers such individuals to be human rights defenders, given that they observe the criteria set forth in the Declaration. He intends to widen and strengthen his cooperation with such individuals as he fulfils the mandate that has been entrusted to him.

F. Developing the distribution of good practices

84. Owing to the actual nature of his mandate, the Special Rapporteur is going to devote the major part of his activities to follow-up on files and to making a contribution to more effective protection of defenders through missions, appeals and communications and also coordination with the stakeholders concerned.

85. However, the Special Rapporteur is conscious that activities of protection and activities of promotion are complementary. In this area, he has been struck by the extraordinary vitality of the defenders, specialized non-governmental organizations and networks of defenders who since the adoption of the Declaration on Human Rights Defenders, in other words in under 15 years, have been able to develop and fine-tune mechanisms of protection, international solidarity and rapid reaction to threats and attacks, including by mobilizing the most modern technological resources and the social networks.

86. Similarly, some States and groups of countries have developed their own tools, guidelines, national legislation and visa-issue and relocation mechanisms to be more capable of warding off infringements of defenders' rights and providing protection to those who need it.

87. Seminars, round tables, platforms and other consultations are regularly organized on every continent to train the defenders and teach them techniques of protection, including how to protect their means of communication against risks of surveillance. These meetings are also a forum for exchanges of good practices in which some learn of the best techniques of others, and the Special Rapporteur will respond affirmatively, to the extent possible, to invitations to him to participate in such gatherings.

88. Finally, the Special Rapporteur intends to play a significant part in the distribution of good practices which can have a multiplier effect on the protection and promotion of the right to defend human rights, provided that they are distributed widely, including to the most isolated defenders.

G. Promoting the dissemination of the Declaration on Human Rights Defenders

89. In the fifteen years after its adoption by the General Assembly in the latter's resolution 53/44, the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms has been very widely disseminated and promoted by various stakeholders. Although a major effort has been made to translate it into an ever-growing number of languages or dialects, it is still too little

known to those who have the particular responsibility to implement it, namely governments, or those who can best benefit from it, namely the human rights defenders themselves.

90. Consequently, in each of the activities which the Special Rapporteur will be led to develop, he will pay attention to the promotional aspect of the Declaration and will encourage States, international organizations and other actors to make an extra effort, over time, to have it translated into a greater number of languages and dialects. He will continue to appeal to the Permanent Missions and other stakeholders to remind them of paragraph 10 of General Assembly resolution 64/163 in which it strongly encourages States to translate the Declaration and to take measures to ensure its widest possible dissemination at the national and local levels.

91. In addition, during each of his missions, he will seek information from the authorities of the countries visited as to the measures taken to promote awareness and training in regard to the Declaration in order to enable officials, institutions, authorities and members of the judiciary to observe the provisions of the Declaration and thus to promote better understanding and respect for individuals, groups and organs of society engaged in promoting and defending human rights, as well as for their work, in line with paragraph 11 of General Assembly resolution 64/163.

92. Finally, because of the threats and risks to which rights defenders living in isolated and remote areas are exposed, he intends to make a special effort to distribute the Declaration to them, making it possible for them to draw benefit from its message of protection.

H. Raising the visibility of the situation of defenders

93. The Special Rapporteur is conscious of the responsibility incumbent upon him to proclaim loud and clear the rights of defenders to any who would contest those rights. It is also his responsibility to state that all who are active in promotion of rights and defend them are de facto defenders, and that someone certainly does not need to be a member of an organization in order to be a defender. It follows then that governments have no right to refuse protection simply because the defender concerned does not belong to an organization.

94. For that reason, he intends to make the issue of the visibility of defenders' work a major priority of his activities, using the means at his disposal and at the same time observing the working rules of the special procedures mandate holders.

95. The Special Rapporteur thus intends to develop communication activities to make the issue of the importance of human rights defenders more visible, working through the press and the social networks such as Facebook and Twitter.

96. He also plans to use the same communication techniques to broaden his interaction with defenders, studying the procedures and methods that will allow them to communicate more directly with him when that is necessary and possible.

I. Combating impunity and reprisals

97. The Special Rapporteur has taken note, with concern, of the reprisals committed against individuals or non-governmental organizations who have

cooperated with special procedures mandate holders, as described in the report of the Secretary-General on Cooperation with the United Nations, its representatives and mechanisms in the field of human rights (A/HRC/24/29).

98. He has also been struck by the number and gravity of the threats hanging over the defenders who enter into direct dialogue with regional or international organizations for protection and promotion of human rights in order to inform them of situations or to expose human rights infringements or violations.

99. Reprisals may take various forms, from threats against the defenders themselves or their families, defamation campaigns, death threats, physical violence, abductions, hounding by law enforcement, assassinations or various forms of harassment and intimidation by the police.

100. The Special Rapporteur refers to the joint statement of 15 March 2012 by the Rapporteurs on Human Rights Defenders from the United Nations, the African Commission on Human and People's Rights and the Inter-American Commission on Human Rights on reprisals against individuals and groups seeking to cooperate with those three institutions. He welcomes the determined stance of the President of the Human Rights Council in calling on States to combat this phenomenon.

101. He also stresses the importance of the joint statement delivered in March 2014 by Botswana on behalf of a group of 47 States to the twenty-fifth session of the Human Rights Council which referred to the call by the Secretary-General and the United Nations High Commissioner for Human Rights for organizational coherence and a systematic approach by the United Nations to protect civil society actors better.

102. The Special Rapporteur is very concerned with this issue and wishes to contribute to raising the awareness of the international community accordingly, notably its awareness of the role that the United Nations must play to deal with the issue and bring States to face up to their responsibilities.

103. He stresses the need to undertake intensified surveillance and action to ensure observance of the normative agreements and rules of procedure of the United Nations, the African Commission on Human and People's Rights and the Inter-American Commission on Human Rights, which explicitly prohibit acts of reprisal by State and non-State actors.

104. The Special Rapporteur intends that one of the main lines of his work will be to combat the culture of impunity, and he plans to research this matter and show in one of his forthcoming reports that it is partially because of the de facto impunity enjoyed by perpetrators of reprisals against defenders that the phenomenon grows and expands.

VI. Conclusions and recommendations

105. **The present report presents the vision and the priorities which the Special Rapporteur wishes to share with the Member States and other stakeholders regarding the way in which he intends to carry out the statutory activities laid down, working in a spirit of openness, frankness and transparency which he will maintain throughout the duration of his office. He is conscious of the importance of this mandate and will devote his time and energy to completing**

the tasks assigned to him, with the overriding objective of serving the underlying cause.

106. He will interpret his mandate as widely as possible in order to make it as effective as possible, at the same time basing his approach on the results obtained by his predecessor, on the knowledge acquired and the working methods used to date, while observing the rules applicable to special procedures mandate holders. But he also plans to explore new paths and innovative working techniques where that appears appropriate.

107. As the central function of the mandate is the protection of the rights of human rights defenders, the Special Rapporteur will place a greater emphasis on the aspects of his duties having to do with promotion of those rights. He will focus his attention on good practices relating to the protection of human rights defenders and to the promotion of the defence of those rights, and on achieving extensive awareness of the Declaration on Human Rights Defenders.

108. The Special Rapporteur hopes to be able to create the conditions that will allow him closer interaction with governments in follow-up to communications and a more effective treatment of the issue of impunity.

109. Understanding the major impact of modern communication techniques, he will make it one of his objectives to create greater visibility for and enhanced awareness of the role played by defenders.

110. The Special Rapporteur has noted with concern the resurgence of reprisals against defenders and he intends to make a contribution to awareness-raising among all actors as to the political responses to be applied to this issue.

111. He intends to follow up more closely on groups needing special protection, in order to be able to put forward a more fitting response to the problems encountered by each of such groups.

112. Finally, the Special Rapporteur intends to strengthen cooperation and develop greater synergy with other mandate holders, regional mechanisms and all stakeholders.

113. In his reports to the General Assembly and the Human Rights Council, the Special Rapporteur will have occasion to make numerous recommendations either to all States or else targeted recommendations annexed to his mission reports. However, he will also be vigilant that his recommendations do not remain without a response and will from time to time carry out an analysis of the responses or lack of responses to his recommendations.

114. The Special Rapporteur welcomes the extension of the mandate and will always be conscious of the preamble and the recommendations of the resolution which will be the guiding lines of his future work.

115. It is his intention at the end of the three years of his mandate to publish an accounting of the implementation of his vision and his priorities as well as information on the difficulties and obstacles encountered.

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Promotion and protection of the rights of children

Status of the Convention on the Rights of the Child

Report of the Secretary-General

Summary

The Convention on the Rights of the Child was adopted 25 years ago by the General Assembly in its resolution 44/25. In its resolution 68/147, the Assembly requested the Secretary-General to submit to it the present report, containing information on the status of the Convention and on issues contained in the resolution, with a focus on progress achieved and challenges in protecting children from discrimination and overcoming inequalities, in the light of the 25 years since the adoption of the Convention. The present report considers the progress achieved and the remaining implementation challenges and gaps in realizing the rights of the child. A number of proposals are made in respect of leveraging resources and innovations to advance the rights of children.

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I. Introduction

1. In its resolution 68/147, the General Assembly requested the Secretary-General to submit to it at its sixty-ninth session a report containing information on the status of the Convention on the Rights of the Child and the issues addressed in the resolution, with a focus on progress achieved and challenges in protecting children from discrimination and overcoming inequalities, in the light of the twenty-fifth anniversary of the adoption of the Convention. The present report is submitted in accordance with that request.

II. Status of the Convention on the Rights of the Child

2. As at 1 July 2014, the Convention on the Rights of the Child[1] had been ratified or acceded to by 194 States. The State of Palestine acceded to the Convention on 2 April 2014. Three States, namely, Somalia, South Sudan and the United States of America, are not yet parties to the Convention.

3. As at 1 July 2014, the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict[2] had been ratified by 156 States and the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography[3] had been ratified by 167 States.

4. In addition, as at 1 July 2014, the Optional Protocol to the Convention on the Rights of the Child on a communications procedure[4] had been ratified by 11 States.

III. Implementation of the Convention on the Rights of the Child

5. During the reporting period, the Committee on the Rights of the Child held its sixty-fourth to sixty-sixth sessions at the United Nations Office at Geneva, from 16 September to 4 October 2013, from 13 to 31 January 2014 and from 26 May to 13 June 2014, respectively.

6. As at 1 July 2014, the Committee had received the initial reports under the Convention of all but two States parties, namely, Nauru and Tonga. All initial reports received by the Committee had been reviewed. In total, since its inception, the Committee had received 636 reports, pursuant to article 44 of the Convention.

7. Furthermore, the Committee had received 101 reports and 1 second periodic report under the Optional Protocol on the involvement of children in armed conflict, and 87 reports and 1 second periodic report under the Optional Protocol on the sale of children, child prostitution and child pornography.

8. The Chair of the Committee will present her oral report to the General Assembly at its sixty-ninth session, in which she will address the major issues

[1] United Nations, *Treaty Series*, vol. 1577, No. 27531.
[2] Ibid., vol. 2173, No. 27531.
[3] Ibid., vol. 2171, No. 27531.
[4] General Assembly resolution 66/138, annex.

related to the work of the Committee during the past year, in accordance with resolution 68/147.

9. The Chair of the Committee will also address the opening meeting of the high-level meeting of the General Assembly on 20 November 2014 on the occasion of the twenty-fifth anniversary of the adoption of the Convention on the Rights of the Child, in accordance with General Assembly resolution 68/273.

IV. Progress achieved after 25 years since the implementation of the Convention on the Rights of the Child

10. Twenty-five years ago, the world set out a vision for its children, in which it committed to do everything in its power to protect and promote their rights to survive and thrive, to learn and grow, to make their voices heard and to reach their full potential. Adopted in 1989, the Convention on the Rights of the Child recognizes the child as a subject of rights that States commit to respect, protect and fulfil, guided by the best interests of the child. Embracing a holistic approach to child development, the Convention also recognizes that all children have a right to survival and development, to grow up free from discrimination, to express their views and to participate in society. In every region of the world, the Convention has inspired changes in laws, institutions and policies to better protect children. Many States have enshrined children's rights into their constitutions and many more have enacted specific legislation that translate the articles of the Convention into national laws. The Convention has also contributed to changing attitudes towards childhood and to the universal understanding that respecting, protecting and fulfilling the rights of children depend on recognizing childhood as a period that is separate from adulthood, defining it as a time when children can grow, learn, play, develop and participate in their communities and societies.

11. The most widely ratified human rights treaty in history, the Convention articulates universal human rights norms and standards for individuals below 18 years of age. While it recognizes the individual path of States Parties to implement the treaty, the Convention stipulates their legal obligations in fulfilling the rights of every child. The Committee on the Rights of the Child, which oversees the implementation of the Convention, has identified four articles as guiding principles of the Convention: non-discrimination or universality (article 2); the best interests of the child (article 3); the right to life, survival and development (article 6); and respect for the views of the child (article 12).

12. The impressive gains for children achieved over the past quarter century command attention and offer much to celebrate in all dimensions of the child-rights agenda set forth in the Convention. The present report will, to the extent possible, be illustrated though key indicators since 1990, the reference year for the Millennium Development Goals and the year in which the Convention came into effect.

Right to life, survival and development

13. Article 6 of the Convention states that every child has the inherent right to life, and that States Parties shall ensure to the maximum extent possible the development of the child. That article is closely related to the child's right to enjoy the highest attainable standard of health and to health services, as elaborated in article 24, as

well as the child's right to education, as described in articles 28 and 29. The child's right to development is also embraced in article 27, which requires that States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. That right was further elaborated through the following general comments of the Committee: 1, on the aims of education; 3, on HIV/AIDS; 4, on adolescent health and development; 7, on early childhood; and 15, on the right of the child to the enjoyment of the highest attainable standard of health. Actions to ensure survival and development span across various domains, including the provision of essential health care, disease prevention and control, nutrition, water supply, sanitation and environmental health, and family guidance and care.

14. The Convention has helped to push children's rights, such as the right to health, up the political agenda as States committed to implementing this and other rights to survival and development when they ratified it. From this perspective, the Convention has acted as a catalyst and an enabler, supporting the global trend towards more effective and affordable treatments and innovative ways of delivering vital interventions, which have led to unprecedented progress in the reduction of child mortality. The global rate of under-five mortality has been almost halved, from 90 deaths per 1,000 live births in 1990 to 48 per 1,000 in 2012.[5] Importantly, the analysis shows that the pace of reducing under-five mortality has more than tripled over the past two decades, from 1.2 per cent for the period 1990-1995 to 3.9 per cent in 2005-2012. Maternal mortality has also decreased, from 543,000 deaths in 1990 to approximately 287,000 in 2010,[6] giving children a better chance of a healthy life. Dedicated efforts to national immunization campaigns indicate a marked progress in eradicating the polio virus, with only 1 per cent of children living in Afghanistan, Nigeria and Pakistan still being exposed to the virus.[7] The Office of the United Nations High Commissioner for Human Rights recently issued a technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), of which the implementation at the national level is expected to contribute to reducing that rate.

15. Notable progress has also been achieved in other child development outcomes. New HIV infections among children under 15 years of age declined by 35 per cent globally between 2009 and 2012,[8] while, according to estimates of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the outlook for children born to mothers living with HIV improved dramatically between 2005 and 2012, with more than 850,000 HIV infections in children prevented. Efforts to fulfil children's right to food have also yielded improved results, with a 37 per cent drop in stunting since 1990.[9] Access to water and sanitation facilities has increased, reaching 2.3 and 2 billion people respectively between 1990 and 2012.[7] The proportion of the global

[5] United Nations Children's Fund (UNICEF), *Committing to Child Survival: A Promise Renewed — Progress Report 2013* (New York, 2013).

[6] World Health Organization and UNICEF, *Accountability for maternal, newborn and child survival: the 2013 update* (Geneva, 2013).

[7] UNICEF, Thematic Report 2013, "Young Child Survival and Development" (New York, 2013).

[8] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS report on the global AIDS epidemic 2013* (Geneva, 2013).

[9] UNICEF, *The state of the world's children in numbers: every child counts* (New York, 2014).

population using improved water sources reached 89 per cent in 2010, up from 76 per cent in 1990.[10] According to the United Nations Development Group, in its thematic paper on Millennium Development Goal 2,[11] in education, major progress has been facilitated through enabling legal, policy and institutional frameworks and sustained public expenditures in primary education. Today, more children are attending school, even in the least developed countries, with the enrolment rate growing from 83 per cent in 2000 to 90 per cent in 2011. Over the same period, estimates show that the number of children out of school worldwide was almost halved, from 102 million to 57 million. Around half of the recent reductions in maternal and infant mortality are attributed to girls' education, especially when mothers have completed primary school and at least lower secondary school.[12] The 40 per cent decline in child labour among girls since 2000, compared with 25 per cent for boys, is also attributed to greater emphasis on girls' education during this period.[13]

Protection and empowerment of the child

16. The protection and empowerment of the child is at the heart of the Convention, which, in its article 19, indicates that children have the right to be protected from being hurt and mistreated, physically or mentally. That right is supported by a number of other articles, including 20-22, 24 (3) and 32-40, which describe a set of actions and approaches States Parties must undertake in order to prevent and address all forms of violence, exploitation and abuse, and ensure that laws, services, behaviours and practices minimize children's vulnerability, address known risk factors and strengthen children's own resilience. The appointment of three special representatives of the Secretary-General, with mandates on violence against children, children and armed conflicts and sexual violence in conflict, anchor protection work and provide direction around specific issues.

17. Governments are increasingly reviewing their child protection systems and prioritizing areas for strengthening. By the end of 2013, 104 countries had identified the nature of their systems and those areas that require an enhanced response, and 74 of them now have results reflected in government budgets, policy papers or legislation, potentially benefiting 690 million children. Specifically, the number of countries with policies in place to prevent and address violence against children has increased by 50 per cent since 2006 (see A/68/274), an estimated 2,538 communities in eight countries now adhere to public declarations to abandon female genital mutilation,[14] while child labour has decreased by about one third its level in 2000.[15]

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[10] The Millennium Development Goals report 2013 (United Nations publication, Sales No. E.13.I.9).

[11] Available from www.undg.org/docs/11421/MDG2_1954-UNDG-MDG2-LR.pdf.

[12] E. Gakidou et al., "Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis", in *The Lancet*, Volume 376 (2010).

[13] International Labour Organization, *Making progress against child labour. global estimates and trends 2000-2012* (Geneva, 2013).

[14] United Nations Population Fund-UNICEF, Joint Programme on Female Genital Mutilation/Cutting: Annual Report 2012 (New York, 2012).

[15] UNICEF, Thematic Report 2013, "Child protection from violence, exploitation and abuse" (New York, 2013).

18. At the international level, there has been an ever-growing ratification and incremental implementation of the principal instruments relating to children's protection from violence, namely, the Optional Protocol on the sale of children, child prostitution and child pornography and the Optional Protocol on the involvement of children in armed conflict. Conflict-related violence recently gained more prominence with the endorsement of the Declaration of Commitment to End Sexual Violence in Conflict (A/68/633, annex), and the adoption of Security Council resolution 2106 (2013) on women, peace and security, which outlines a comprehensive approach and framework to prevent conflict-related sexual violence. The United Nations Children's Fund (UNICEF) has played an important role in ensuring that countries have in place a protective legal framework in relation to child discipline. The former Yugoslav Republic of Macedonia is the most recent country to date to achieve legal reform prohibiting all corporal punishment of children in all settings, including the home, bringing to 36 the total number of States to adopt such a measure. There has been an increase in the number of countries prohibiting corporal punishment in schools, from 117 in 2012 to 122 in 2013.

19. In recent years, humanitarian reform efforts, including the Transformative Agenda of the Inter-Agency Standing Committee, have strengthened humanitarian response through improved partner coordination and technical capacity development, increased predictability and deeper commitment to accountability to affected populations. The rights enshrined in the Convention now provide the framework for much of the inter-agency cluster system's commitments to action in health, nutrition, education, water and sanitation, child protection and HIV/AIDS. As a result, humanitarian response is increasingly more strategic, coordinated and effective in delivering results for children.

20. International human rights and humanitarian law apply concurrently during times of armed conflict. The Convention and its Optional Protocols thus provide a critical international legal framework for the protection of children in armed conflict. The Security Council embraced the norms and standards set by the Convention and referred to it in numerous resolutions on the situation of children in armed conflict. In its resolution 1612 (2005), the Council requested the Secretary-General to implement a monitoring and reporting mechanism, to provide timely and reliable information on grave violations of children's rights during armed conflict. Since the adoption of the resolution, the Secretary-General has received information about six grave violations of children's rights. As a result, children's rights have become more integrated into the work of the Council.

21. Action by the Security Council has strengthened protection on the issue of children in armed conflict, which is the subject of the Optional Protocol on the involvement of children in armed conflict. In its resolution 1882 (2009), the Council required parties to armed conflict engaging in patterns of killing and maiming of children and/or rape and other sexual violence against children to be listed in the annexes to the reports of the Secretary-General on children in armed conflict. The same year saw the unanimous approval of resolution 1888 (2009), by which the Council urged Member States to take concrete steps to stop the use of sexual violence as a tactic of war and mandated peacekeeping missions to uphold the protection of women and children from sexual violence during armed conflict. More recently, in its resolution 1998 (2011), the Council has taken steps to protect children's rights to health services and education, by designating any attacks on

schools or hospitals by armed groups as a grave violation of children's rights, triggering the automatic listing of violating parties.

The right to participation

22. Children's rights to be heard and respected in matters that concern them, including having their views sought in judicial proceedings that affect them, are reflected through several provisions of the Convention. However, article 12 expressly articulates States Parties' obligations to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". It also states that "the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings". In that article, together with articles 5 and 13-17, the Convention conveys the idea of children as active participants in their own development, rather than as mere recipients of adult protective care. General comment 12, adopted by the Convention in 2009, further elaborates the scope of article 12, articulating what action governments are expected to take to implement article 12, and how to interpret its meaning.

23. While the translation of this ideal into reality at times proved to be elusive, States Parties' efforts to establish national children's and youth councils or parliaments reflect their intention to strengthen children's participation in matters that affect them (see E/CN.9/2012/5). There is also evidence of children and adolescents' engagement in programme development and policymaking processes. In Brazil, for example, children's voices were instrumental in developing national guidelines on the implementation of adolescent-friendly health services and drafting policies in support of indigenous populations.[14] Similarly, in Mozambique, the a participatory child rights media network has facilitated the inclusion of children's voices in programming related to disaster risk reduction, the prevention of HIV/AIDS among adolescents and disabilities.

24. Children are also increasingly involved in the Convention reporting process, either by contributing their the State Party's reports or by preparing alternative reports, such as in the case of India.[16] On occasion, children also come to Geneva and participate in special meetings with the Committee.

25. The process of elaborating the sustainable development goals has contributed to a strengthened recognition of the value of citizen participation and served as a platform to amplify the opinions of children and young people with respect to public matters affecting them. A number of efforts have been made to include the voices and recommendations of children in the post-2015 development agenda. Between 2012 and 2014, children and young people from diverse backgrounds across every region of the world have been involved in online and face-to-face consultations, sharing their opinions on global and local development issues. In Nepal, for example, recommendations from 15,000 children's clubs fed into national policy design, influencing the decision to allocate 10-15 per cent of the local budget to children in the most disadvantaged situations.

[16] Available from http://tbinternet.ohchr.org/Treaties/CRC/Shared%20Documents/Ind/INT_CRC_ICO_Ind_15693_E.pdf.

26. The celebration of the twenty-fifth anniversary of the adoption of the Convention coincides with the entry into force of the Optional Protocol on a communications procedure. By allowing children to seek remedies and bring complaints on the violations of their rights under the Convention and its two Optional Protocols before the Committee on the Rights of the Child. The Optional Protocol on a communications procedure consolidates an international system of accountability for the realization of children's rights.

V. Implementation challenges and remaining gaps in realizing the rights of the child

27. There is an increasing recognition of the widespread inequities affecting the poorest and most vulnerable children. In the developing world, children from the poorest income quintile are three times as likely to be out of school, nearly three times as likely to be underweight and twice as likely to die before the age of five as those from the wealthiest quintile.[17] Overall, while extreme poverty declined globally, evidence shows that 568 million children are still living in extreme poverty, including 400 million children under the age of 12.[18] According to a recent profile of the world's extreme poor by the Organization for Economic Cooperation and Development (OECD),[19] 47 per cent of those living on less than $1.25 a day are 18 or under. Meanwhile, 30 million children, equal to one child out of every eight in the OECD countries, are growing up poor. Furthermore, child poverty has been increasing in many of these countries in recent years as a consequence of the economic crisis, showing that child poverty is a global issue and not just one for the developing world.

28. The disproportionate concentration of extreme poverty among children remains a huge barrier to the fulfilment of children's rights, with long-term implications for their families, communities and the rest of society (see ECA/ICPD/EXP/2013/2). Children and adolescents are particularly vulnerable to the impacts of poverty because of their evolving capacities and physical and mental needs. Early experience of poverty and deprivation can have devastating effects on children's long-term development, creating and maintaining intergenerational cycles of poverty. Underlying factors, such as gender, disability, ethnicity, harmful sociocultural norms and behaviours, conflict and humanitarian crises, may further exacerbate children's vulnerability and deepen discrimination and exclusion. Societies and countries also pay an enormous price for the high levels of child poverty, through reduced productivity, increased vulnerability to climate change, untapped potential and the costs of responding to chronic poverty and rising inequality.

29. The caseload for humanitarian action continues to grow each year, with children and women disproportionately affected by external shocks, such as economic crises, climate change, natural disasters, diseases or violent conflicts. In recent years, the humanitarian system has experienced an unprecedented number of severe crises occurring at the same time, bringing ever-greater urgency to advocacy

[17] UNICEF, Issue brief: child poverty in the post-2015 agenda (New York, 2014).

[18] P. Olinto et al., "The state of the poor: where are the poor, where is extreme poverty harder to end and what is the current profile of the world's poor?", in *Economic Premise*, Number 125 (World Bank, Washington, D.C., 2010).

[19] Available from www.oecd.org/els/soc/OECD2014-Income-Inequality-Update.pdf.

and monitoring efforts based upon the Convention and its protocols. Children in humanitarian situations and post-crisis transition contexts face a dramatically greater risk of violation to their rights, as health and water systems become overstretched, learning is interrupted and the threat of exploitation and abuse increases. Two out of every three children who die before the age of five live in fragile and conflict-affected contexts.[20] Children with disabilities are most vulnerable in these contexts and face the greatest risk of injury, abuse and neglect.

The right to child survival and development

30. Persisting challenges in protecting children's right to life are attributed to the lack of attention and investment rather than to the lack of knowledge on life saving interventions. According to recent data,[5] 216 million children died before their fifth birthday since 1990, more than the current total population of Brazil. The estimates also indicate that 2.9 per cent of newborn babies die of preventable causes within the first 28 days of life, with deaths caused mainly to poorly resourced health services and lack of culturally appropriate health care. In terms of regional perspective, West and Central Africa have seen under-five mortality rates fall by just 39 per cent since 1990, the lowest reduction among all regions. Those two regions are also experiencing the highest rate of mortality, with almost one in every eight children dying before the age of 5, a situation that is exacerbated by the recent severe outbreak of the Ebola virus.

31. Addressing the challenges of undernutrition and stunting are closely interlinked with the unfinished agenda of child survival and development. As one of the main underlying causes of under-five mortality, undernutrition accounted for 45 per cent deaths in 2011. A result of multiple deprivations in terms of poor living conditions, including household food insecurity, low levels of parental education, lack of access to quality health care and an unhealthy living environment, stunted growth affects 162 million children worldwide. Recent estimates indicate that children in the poorest quintile were twice as likely to be stunted as those in the richest quintile.[7] Inadequate nutrition not only heightens a child's susceptibility to death from infectious diseases, such as pneumonia, diarrhoea and malaria, but may also result in long-lasting, cognitive and physical impairments, including intellectual disability, elevated risk of adult-onset cardiovascular disease and diabetes.[6] Perhaps more importantly, evidence shows that chronic food insecurity and inadequate diets, exacerbated by scarcity of resources, perpetuate the intergenerational poverty cycle, as undernourished girls have a greater likelihood of becoming undernourished mothers, who in turn have a greater risk of giving birth to undernourished children.[21]

32. Despite the growing evidence of the efficacy of early childhood development policies and programmes and enhanced resources on improved education, health and nutrition outcomes for children, over 200 million children under five in low and middle-income countries will not reach their developmental potential.[22]

[20] World Bank, *World Development Report: Conflict, Security and Development* (Washington, D.C., 2011).

[21] Save the Children, *Nutrition in the first 1,000 days: state of the world's mothers 2012* (London, 2012).

[22] S. Walker et al., "Child development: risk factors for adverse outcomes in developing countries", in *The Lancet*, Volume 369, Issue 9556 (2007).

33. Access to adequate sanitation is a major safeguard against infections and undernutrition. Although sustained and substantial investments in sanitation yielded significant results between 1990 and 2011, 36 per cent of the world's population still lacks access to improved sanitation facilities. Between 1990 and 2011, sanitation coverage increased from 49 to 64 per cent.[10] In South Asia, for example, improved sanitation increased from 2 to 7 per cent between 1995 and 2008, a development that barely benefitted the poorest 40 per cent of the population. Moreover, 768 million people, 82 per cent of whom are in rural areas, live without access to a clean water supply.

34. Access to HIV testing and antiretroviral treatment has drastically improved since the adoption of the Convention. However, in low- and middle-income countries, coverage of such treatment for children under the age of 15 has consistently been around half that for adults, 34 compared with 64 per cent for adults in 2012.[8] The rates of early infant diagnosis remain low. Only 39 per cent of children in low and middle-income countries were estimated to have access to HIV testing within the recommended 2 months of birth in 2012.[23] The international community is also failing the 2.1 million adolescents aged 10-19 living with HIV around the world in terms of providing prevention and treatment services and offering them continued care and support during their transition from paediatric to adult health care services.[24] In the past seven years, the 10-19 year age group is the only one in which AIDS-related deaths have increased. In 2012, over 85 per cent of all adolescents with HIV lived in sub-Saharan Africa and over 90 per cent of those AIDS-related deaths among adolescents occurred in this same region. Gender inequality coupled with social and economic inequalities play a marked role in the vulnerability of adolescent girls and the disproportionate levels of HIV among them. In sub-Saharan Africa, adolescent girls and young women account for approximately 60 per cent of all adolescents and young people living with HIV, as of 2012. Two thirds of new HIV infections in adolescents are among girls.

35. In education, much progress took place between 1989 and 2004, and efforts to get more children into school have stalled over the past few years. Furthermore, the progress on gender parity in primary school enrolment has led to the mistaken impression that the task has been completed, when in reality girls in many countries continue to be deprived of quality schooling and especially the opportunity to enter and complete secondary schooling. Today, there are still 57 million children of primary school age who are not in school and 69 million adolescents who are not in secondary school. In sub-Saharan Africa, only 93 girls are enrolled in primary school for every 100 boys.[10] For many children, entry into the classroom is only partial progress, as 25 per cent of children worldwide do not reach and complete the last grade of primary education. In 2011, about 137 million children began primary school, but 34 million are expected to leave school before reaching the last grade. Sub-Saharan Africa and South and West Asia have the highest rates of early school-leaving. Furthermore, across those regions, more than one in three students who started primary school in 2011 will not make it to the last grade. Further compounding these challenges is what has recently been called the "learning crisis" caused by a host of issues related to irrelevant and outdated curriculums, a lack of qualified teachers, inadequate assessments and standards and a shortage of

[23] UNAIDS, *Global AIDS response progress reporting 2012* (Geneva, 2012).

[24] Susan Kasedde et al., "Reducing HIV and AIDS in adolescents: opportunities and challenges", in *Current HIV/AIDS Reports*, Volume 10, No. 2 (2013).

appropriate learning materials. An indication of the cumulative effect of these factors on poor learning outcomes is evidenced through recent data suggesting that up to 250 million children (or one in every three children) who attend school reach the age of 10 without acquiring basic literacy, numeracy and life skills.[25]

The right to protection

36. Advances in child protection have been grounded in a much deeper understanding of the dynamics of social norms and the actions needed to promote positive norms aimed at ending harmful practices. This has been complemented by efforts to improve national capacities to better document and understand the scale, scope and depth of child abuse, exploitation and neglect. Critical investments in household data collection instruments, such as the Demographic and Health Survey and the Multiple Indicator Cluster Survey, have helped to shape national policies and programmes and played a vital role in raising awareness about the extent of protection risks facing children.

37. However, millions of children continue to be exposed to the cumulative impact of different manifestations of violence, exploitation, abuse and neglect. Given the multiple and overlapping violations faced by children today, there is a need to ensure much stronger accountability for child-rights violations and inter-sectoral coordination, supported by proven, budgeted strategies and legislation that is mutually reinforcing and that help to put an end to child rights violations. Each year, according to the Secretary-General's study on violence against children,[26] between 133 million and 275 million children witness episodes of violent behaviour between their parents. According to a global school-based student health survey, between 20 and 65 per cent of school-aged children had reported incidents of verbal or physical bullying in the previous 30 days. Children with disabilities are almost four times more likely to be victims of any sort of violence and three times more likely to be victims of sexual violence. The prevalence of female genital mutilation has declined in many countries. However, more than 125 million girls and women alive today have been cut in the 29 countries in Africa and the Middle East where that practice is concentrated.[27]

38. Ensuring that all children are registered immediately after birth is central to their right to have access to basic services, including health care, social security and education. However, globally, this fundamental right has been denied to 230 million children under five years of age, with sub-Saharan Africa and South Asia experiencing the lowest rates of birth registration among all regions.[7] With continued high rates of child marriage in South Asia and sub-Saharan Africa, and with a projection that, between 2011 and 2020, 50 million girls will be married before they turn 15,[9] addressing child marriage remains a high priority within child protection agenda. In this context, it is important to recognize that child marriage often leads to early pregnancy and exacerbates the health risks of young adolescent mothers. According to the World Health Organization (WHO), in low- and middle-income countries, complications from pregnancy and childbirth are a leading cause of death among girls aged 15-19 years. Stillbirths and newborn deaths are 50 per

[25] UNICEF, Thematic Report 2013, "Basic Education and Gender Equality" (New York, 2013).

[26] Available from www.unicef.org/ceecis/sgsvac-cyp.pdf.

[27] UNICEF, *Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change* (New York, 2013).

cent higher among infants born to adolescent mothers than those born to mothers aged 20-29 years.[28] Ensuring that adolescents have access to accurate information about sexual and reproductive health as well as access to health services and education is thus of perennial importance.

39. Around the world, an estimated 150 million children aged 5 to 14 are still engaged in child labour, accounting for almost 15 per cent of all children. Recent years have seen a marked increase in trafficking of children. Data available for the reporting periods 2003-2006 and 2007-2010 show an increase from 20 to 27 per cent, respectively, with two of every three trafficked children being girls.[29] In some regions, more than 60 per cent of detected victims are children, girls being the hardest hit. In April 2014, a terrorist group abducted nearly 300 schoolgirls in Nigeria, most of whom currently remain under the control of the terrorists and are in severe danger of being enslaved. Child trafficking is a serious form of violence, leading to further violations of rights, as children are, for example, enslaved into prostitution, sold into marriage, coerced to work in plantations or deep-sea fishing, forced to beg on the street or recruited by criminal networks. Similarly, children facing the criminal justice system often see their rights compromised, including as a result of violence while deprived of liberty and inhuman sentencing, flogging, stoning, amputation, life imprisonment and even the death penalty. As persons who are victims, witnesses or offenders, in need of protection measures, affected by status offences or criminalized for involvement in petty crime, children face long periods of pretrial detention and may be exposed to physical, psychological and sexual violence (see A/HRC/21/25).

The right to participation

40. The full realization of children's participation rights continues to be hampered by cultural and discriminatory attitudes and practices as well as by political, legislative and economic barriers. Younger children, girls, children with disabilities, working children or those out of school, children from indigenous or minority communities, and children growing up in poverty often find the right to participation and self-expression particularly elusive. Lack of access to information prevents many children from knowing their rights. For example, the Convention has not been translated into certain minority languages or sufficiently disseminated, which disproportionately diminishes the awareness of children belonging to ethnic and indigenous groups of their rights and fundamental freedoms, including their right to participation (see A/67/225). Furthermore, the lack of information on sexual and reproductive health in a number of countries restricts adolescents' ability to make informed decisions about their health.

41. The rise in structural mechanisms that enable children to participate in decision-making, through school and youth forums, children's parliaments and judicial proceedings, has contributed to a cultural change in the value that children, adults and organizations are now placing on public expression of children's voices. However, questions are genuinely taken into account about the extent to which children's views in such forums, and concerns persist about the lack of regular and

[28] See www.who.int/mediacentre/factsheets/fs364/en.

[29] United Nations Office on Drugs and Crime, Global report on trafficking in persons (Vienna, 2012).

sustained resources to support them, potentially rendering such platforms as symbolic and ineffective.

42. Despite efforts to reach children in the most marginalized situations through consultative processes, it is recognized that the participation of many children is hindered by little or no access to the Internet and by literacy and language barriers. A further challenge is to ensure that the outcomes of these consultations feed into the post-2015 narrative and in the articulation of concrete goals and targets.

43. More needs to be done to spell out the benefits of ensuring children's rights to participation. Evidence in this regard is not complete. In part, this is due to the lack of comprehensive monitoring and evaluation approaches to children's participation. The potential for improved monitoring has been enhanced by the adoption of general comment 12 of the Convention, which elaborates on the scope of article 12, and further strengthened by an accompanying resource guide.[30] However, more rigorous measurement is required of the actions taken to implement the right embodied in article 12 of the Convention. Greater focus is also warranted on the ratification of the Optional Protocol on a communications procedure. To become a truly meaningful mechanism of redress for children, enabling them to bring complaints to the Committee , more efforts need be made on increasing the number of ratifying States Parties.

VI. The way forward: leveraging resources and innovations to advance the rights of children

44. As the discourse on child rights continues to evolve, a stark reminder of the unfinished agenda demands sustained focus and action to address the persisting and widening concerns. A call to renew the existing commitments is thus imperative, with an emphasis on reducing the implementation gap between the principles and the rights enshrined in the Convention and the actual living conditions of the most marginalized and excluded girls and boys who are left behind.

45. Recognizing that, given the pressing global challenges, driven by climate change, food and water insecurity, changing population dynamics, youth unemployment and social conflict, solutions might not be found within traditional development paradigms, the quest for novel approaches has never been greater. Indeed, exploring alternative paths requires changing beliefs, using basic practices and the innovative use of resources to further accelerate progress and current achievements.

46. In this context, the issues and actions below merit further scrutiny by governments and international actors.

Scale-up the delivery of integrated, high impact interventions focusing on the most excluded and marginalized

47. Country experiences show that progress, such as sharp reductions in preventable child deaths, increased number of children at school and strengthened social protection systems, are possible when concerted and

[30] Available from www.unicef.org/ceecis/Child_Youth_Resource_Guide.pdf.

integrated action, adequate resources and political will are consistently applied in support of children's rights and well-being. By creating closer linkages between different elements of well-being, multisectoral interventions have the potential to contribute to a broad range of complementary development outcomes and increased efficiency and effectiveness in service delivery for the most disadvantaged.

48. Efforts to strengthen community-based, front-line child health services in the integrated management of childhood illness and immunization, including community engagement, have not only contributed to a common understanding of child survival and a greater demand for health services, but are also effective in achieving results on multiple fronts.

49. Similarly effective are those programmes that integrate essential health, nutrition and HIV/AIDS-related interventions across the entire continuum of care, offering services for growth monitoring, antenatal and postnatal visit reminders, HIV/AIDS lab results delivery and supply and logistics support for essential medicine. The past decade has seen a dramatic shift with regard to sanitation services, away from technically based, supply-driven approaches towards a focus on demand-driven approaches, rooted in community leadership, behaviour and social norm change, and local innovation. These community approaches to achieving total sanitation are enabling communities to become open defecation-free, contributing to improved health and nutrition for children.

50. Addressing the disproportionate concentration of children living in extreme poverty and reducing the persistent disparities in health, education and other crucial child well-being indicators are developmental challenges that are closely interlinked. The Millennium Development Goals have proved to be a guiding force that have and continue to improve the lives of many disadvantaged families and children around the world. Ensuring that the new priorities included in the post-2015 development agenda prioritize the poorest and most vulnerable children will be critical to eradicate extreme poverty and promote equity.

51. Extensive evidence now shows how social protection programmes, and cash transfers in particular, have significant impacts on multiple dimensions of child poverty, including increases in school enrolment, access to health care and reduced rates of malnutrition. Emerging evidence from Brazil, Ecuador, Malawi and Nicaragua highlights the impacts of social protection programmes on child labour and child marriage, by addressing the poverty that underlies these practices through integrated approaches. Furthermore, growing evidence suggests that, rather than leading to dependency, social transfers help to promote investment in households' productive activities while creating income multiplier effects in local economies. There is also a growing consensus of the importance of both scaling up social protection programmes and, crucially, building integrated social protection systems to avoid fragmentation and enhance the efficiency of their interventions.

Leverage the strengths and resources of broad-based, multi-actor partnerships

52. Over the past two decades, new pathways for solving entrenched development problems have emerged, which seek to build coherence among the

actions of a wide range of partners, including governments, civil society, the private sector and academia.

53. Multi-stakeholder partnerships have proved to be effective in addressing critical bottlenecks as they leverage the strengths and resources of various partners to accelerate results for children. The steady decline in child mortality over the past two decades has been attributed to the increased use of high-impact health interventions, scaled up through multi-actor initiatives. Initiatives such as Committing to Child Survival: A Promise Renewed, Every women, every child, the Global Alliance for Vaccines and Immunization (GAVI Alliance), and Scaling Up Nutrition are central to achieving this. For example, the members of the GAVI Alliance, which brought together multilateral organizations such as WHO, UNICEF, the United Nations Population Fund and the World Bank, civil society, private philanthropists, donors, the vaccine industry and Governments of the implementing countries, contribute through participation in the strategy and policy-setting, fundraising, advocacy, vaccine development and procurement, country support and immunization delivery.

54. Similarly, the strength of public-private partnerships, such as the Global Fund to fight AIDS, Tuberculosis and Malaria and the Roll Back Malaria Partnership, lies in the diversity of partners and in their ability to rally all sectors of society towards the common goal of reducing cases of infectious diseases, saving lives and alleviating the poverty caused by malaria. Scaling Up Nutrition, which currently engages 50 countries, provides opportunities to explore new mechanisms to enhance nutrition-specific programmes through strengthened multi-sectoral synergies and actors. Collaborative, result-oriented partnerships such as these are critical to delivering results for children and realizing their rights.

Leverage the use of new technologies and data availability for programme design and delivery

55. The strategic use of technology can solve problems of time, distance and coordination in the delivery of services. Technology can also lead to strengthened data collection and analysis to inform policy formulation, as well as increased aid effectiveness and greater transparency and accountability. Web and mobile Geographic Information Systems-based platforms facilitate the collection of information from various datasets while enabling partners to identify evolving vulnerabilities alongside critical barriers and bottlenecks. This creates opportunities to monitor the progress of programmes and services and resolve them through targeted investments.

56. In the area of health, for example, real-time monitoring facilitates better linkages between community health services and the formal health system in underserved and remote communities. The transportation of blood samples and test results, especially for rural clinics, is one of the biggest obstacles facing early infant diagnosis and the initiation of antiretroviral therapy for HIV-positive infants, significantly reducing their chance of survival. In Zambia, for example, 30 per cent of children die before the age of one if no interventions for paediatric HIV care and support are provided. The promising results of Project Mwana indicate that the use of mobile phone text messaging can strengthen the early diagnosis of HIV in infants by reducing delays in transmitting results

from the HIV test laboratories to rural health facilities, cutting the total delivery time from 66 to 33 days on average.[31] There is also an indication that the RemindMi application can be used trace community health workers, to achieve improved rates of postnatal follow-up and an increased number of clinic visits for mothers.

57. Children whose births are unregistered may not be able to access health and education services and be protected from violence, exploitation and trafficking. In countries such as Brazil, India and Senegal, experiences suggest that performance monitoring of local registration centres, free text messaging provided by mobile providers and established links between community centres and national authorities can help to significantly increase the number of registered births.

58. Real-time information has been used to expedite the family tracing and reunification process in conflict and emergency situations, by collecting and sharing information on unaccompanied, separated and highly vulnerable children. Such was the case with the influx of refugees from the Democratic Republic of the Congo into Uganda in 2012, internally displaced persons in South Sudan and, more recently, in response to the devastating impact of typhoon Haiyan in the Philippines.

59. The real-time monitoring approach has also been put to use to enhance the quality of the education system in Uganda. Edutrac, for example, collects information on school enrolment, attendance, effective delivery of textbooks and school sanitation infrastructure. The system allows reporters, including school principals, students, and community members, to send alerts via text messaging, triggering the mobilization of resources and actions to protect children from abusive teaching practices, speed up school construction and reduce teacher absenteeism. Edutrac has already generated a dynamic dialogue between the community and the Government, increasing accountability in over 3,500 schools with the collaboration of 10,000 reporters.

60. The same principle underpins the "U-Report" system, also in Uganda, which enables mass citizen participation in real-time monitoring on a wide range of health, education and child protection issues, via mobile phones. Discussions cover topics related to teacher absenteeism, children with disabilities, birth registration, child marriage and corporal punishment. With 257,000 people registered, some 20,000 young people responding to each bi-weekly poll and the results being communicated in the media, the system is strengthening the accountability of both service providers and parliamentarians.[32] In general, the use of information and communications technology for social accountability purposes has the potential to strengthen participation by children and adolescents.

Build resilience for children through risk-informed programmes

61. By upholding the rights of children regardless of context, the Convention provides a stable normative bridge between humanitarian situations and development contexts, as well as a consistent legal framework within the

[31] See www.who.int/bulletin/volumes/90/5/11-100032/en/.

[32] See www.unicef.org/infobycountry/uganda_62001.html.

different elements of humanitarian action, from preparedness to early recovery. The Convention calls upon duty-bearers to consider the realization of children's rights a priority at all times. In holding to these commitments, humanitarian agencies and States Parties are increasingly applying risk-informed programming approaches to protect the rights of children in high-risk and high-threat environments. However, more remains to be done to enhance the linkages between humanitarian and development programming and to lay the groundwork for resilience, recovery and renewed development.

62. Sound risk assessments lead to risk-informed programming. The scope of risks to children to be considered should include all forms of risk, such as those encountered by children in disaster situations arising not only from natural hazards but also from conflict or civil unrest, or disease outbreaks. Many children find themselves living with multiple risks and multiple hazards at once. Areas of focus for humanitarian action must be made on the basis of mappings of vulnerability that reflect these complexities.

63. Implementing resilience-building programme modalities and humanitarian action will enhance the ability of children, households, communities and systems to anticipate, manage and overcome shocks and cumulative stresses. Basic social services for children should be risk-informed and prioritized in risk-prone communities. In this regard, the nexus of development work and humanitarian action for children should be strengthened and used as an entry point to building new forms of partnerships to address the rapidly changing humanitarian landscape.

64. The participation of communities and children, especially the most marginalized and at-risk, in local planning, budgeting and monitoring of risk assessment, as well as prevention, emergency preparedness, response and recovery, can greatly enhance resilience, especially at the subnational level. Well-coordinated approaches of all development sectors and strong partnerships will also contribute to the same end.

Secure efficient, equitable and sufficient investment

65. As noted above, persisting challenges in realizing child rights are often attributable to a lack of priority and investment rather than to a lack of knowledge of the most effective, life-saving and equity-promoting interventions for children. The Committee has emphasized that States, whatever their economic circumstances, are required to undertake all possible measures towards the realization of the rights of the child (see CRC/GC/2003/5). There nonetheless remain significant gaps in translating policies into budget allocations for key policies and programmes to improve the situation of children and the realization of their rights. Further progress requires a major, committed increase in the efforts of national governments to mobilize resources, including through official development assistance and tax revenues, as well as political will to prioritize children's rights in resource allocation.

66. Requirements in terms of domestic resources are aimed not only at progressively securing adequate resource allocations, but also at improving the quality of public spending, to make it more transparent, efficient and equitable. Policy and budget decisions should be informed by an analysis of the situation for children made on the basis of timely, comprehensive and disaggregated data. Such analyses are crucial for efficient spending and for services to reach the most vulnerable and marginalized children.